93-120

No. ——

IN THE
Supreme Court of the United States
OCTOBER TERM, 1993

THOMAS JEFFERSON UNIVERSITY
d/b/a THOMAS JEFFERSON UNIVERSITY HOSPITAL,
Petitioner,

v.

DONNA E. SHALALA, Secretary
Department of Health and Human Services,
Respondent.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

PETITION FOR A WRIT OF CERTIORARI

H. GUY COLLIER
Counsel of Record
AMY E. HANCOCK
McDERMOTT, WILL & EMERY
1850 K Street, N.W.
Suite 500
Washington, D.C. 20006
(202) 887-8000

JAMES M. GAYNOR, JR.
McDERMOTT, WILL & EMERY
227 West Monroe Street
Chicago, Illinois 60606
(312) 372-2000
Counsel for Petitioner

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

QUESTION PRESENTED

As it is relevant to this action, the Medicare Act and regulations provided that hospitals furnishing services to Medicare beneficiaries should be reimbursed for the "reasonable cost," including direct and indirect costs, of such services. The clinical training of residents in this country has traditionally taken place in hospitals, and the Medicare program has always recognized that services provided by residents to Medicare beneficiaries relate to patient care and thus the costs of those services are includable in a hospital's "reasonable costs." Teaching hospitals that operate graduate medical education programs have increased costs which are necessary in delivering health services to Medicare beneficiaries. Until communities undertake to bear those costs, Congress directed that the Medicare program share appropriately in the costs of such graduate medical education activities. Regulations implementing the Medicare program provide, however, that costs cannot be "redistributed" from educational units to patient care units, although "redistribution" is not defined. Here, the Hospital, which is owned by an entity which also owns a medical school, claimed certain indirect costs of its related Medical School necessarily incurred in the operation of the Hospital's approved graduate medical education programs. The Secretary created an irrebuttable presumption that because those costs had not previously been claimed for reimbursement by the Hospital, they necessarily had been borne by the community (the Medical School) and therefore the Hospital's claim for reimbursement for the costs was a prohibited "redistribution." The question presented for review is:

1. Whether the Secretary's presumption of community support for programs based on a hospital's failure to claim the costs of those programs in the past, and her decision thereafter to deny payment of those costs on the grounds that they are an impermissible "redistribution" is arbitrary, capricious, an abuse of discretion and not in accordance with law.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

No. ——

THOMAS JEFFERSON UNIVERSITY
d/b/a THOMAS JEFFERSON UNIVERSITY HOSPITAL,
Petitioner,

v.

DONNA E. SHALALA, Secretary
Department of Health and Human Services,
Respondent.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

PETITION FOR A WRIT OF CERTIORARI

Petitioner Thomas Jefferson University d/b/a Thomas Jefferson University Hospital (the "Hospital") respectfully requests that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Third Circuit, entered on April 21, 1993.[1]

OPINIONS BELOW

The United States Court of Appeals for the Third Circuit issued a judgment, but no opinion. The judgment is not reported, and is reprinted in the Appendix at 1a.

[1] All parties are named in the caption. Thomas Jefferson University is a private, not-for-profit educational institution. Therefore, no Rule 29.1 statement is required.

The opinion of the United States District Court for the Eastern District of Pennsylvania is not reported. It is reprinted in the Appendix at 3a.

There are two administrative decisions concerning this case. The Provider Reimbursement Review Board ("PRRB") is the administrative tribunal with jurisdiction to hear and review Medicare reimbursement disputes. Its decision in this matter, PRRB Dec. No. 90-D5, is reported in Medicare & Medicaid Guide (CCH), ¶ 38,276 (Nov. 17, 1989), and is reprinted in the Appendix at 38a. The Administrator of the Health Care Financing Administration ("HCFA") is the agent of the Secretary of the Department of Health and Human Services (the "Secretary") with authority for reviewing PRRB administrative determinations. Decisions of the Administrator constitute final agency action. The Administrator's decision is reported in Medicare & Medicaid Guide (CCH), ¶ 38,353 (Jan. 18, 1990), and reprinted in the Appendix at 28a.

JURISDICTION

The judgment of the United States Court of Appeals for the Third Circuit was entered on April 21, 1993. This Court has jurisdiction to review the judgment of the court of appeals by writ of certiorari pursuant to 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

Petitioner asserts that the Secretary's interpretation of regulations concerning the proper reimbursement for graduate medical education ("GME") costs was arbitrary, capricious, an abuse of discretion and not in accordance with law. The relevant statutory section, 42 U.S.C. § 1395x(v)(1)(A), and regulations, 42 C.F.R. §§ 413.85(a), (c) and (g), and 42 C.F.R. § 413.17(a), are set forth in the Appendix at 61a, 62a, and 63a, respectively.

STATEMENT OF THE CASE

Petitioner brought suit in the district court under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.*, commonly known as the Medicare Act. Jurisdiction in the district court was proper pursuant to 42 U.S.C. § 1395oo(f).

Thomas Jefferson University is a private, not-for-profit educational institution which operates, among other things, the Jefferson College of Medicine (the "Medical School") and the Thomas Jefferson University Hospital (the "Hospital"), a 700-bed teaching hospital. The Hospital is the licensed operator of GME programs (programs for the medical training of interns and residents) involving various medical specialties and subspecialties for 320 full-time equivalent residents. (8a). The Hospital's GME programs are approved, and there is no dispute that they contribute to the quality of patient care in the Hospital. (17a). This case concerns the appropriate interpretation of the Medicare statute and regulations, application of which determines the amount of Medicare reimbursement due Petitioner for operation of its approved GME programs in its 1985 fiscal year. Specifically, the question presented is whether the Hospital is entitled to Medicare reimbursement for the costs incurred by its related Medical School in support of the Hospital's approved GME programs.

There is no dispute that Congress recognized the value of GME programs in enhancing the quality of patient care in health care institutions. Until the community at large undertakes the responsibility to pay the costs associated with GME programs, Congress directed that "part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by [Medicare]." S. Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S.C.C.A.N. 1943, 1977. Thus, from

the very inception of the Medicare program, it has been recognized that costs incurred by teaching hospitals for medical education programs should be treated in the same manner as all other costs, and reimbursed by the Medicare program appropriately.

At all times relevant to this case, GME program costs were reimbursed on the basis of "reasonable costs." The Medicare statute defines "reasonable costs" broadly:

> The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services . . . .

42 U.S.C. § 1395x(v).

Applicable Medicare regulations also suggest that "reasonable costs" are to be defined broadly to include:

> all necessary and proper expenses incurred in furnishing services, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans. *It includes both direct and indirect costs and normal standby costs.*

42 C.F.R. § 413.9(c)(3) (emphasis added). The term "necessary and proper costs" is similarly defined broadly to mean "costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities." 42 C.F.R. § 413.9(b)(2). The regulations also provide that these general principles may be supplemented by more specific regulations providing that the "reasonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included." 42 C.F.R. § 413.9(b)(1).

The regulations at 42 C.F.R. § 413.85 are the governing regulations for the reimbursement of costs associated

with educational activities. Section 413.85(a) provides that "a provider's allowable cost may include its net cost of approved educational activities, as calculated under paragraph (g) of this section." Section 413.85(g) mandates that the reasonable costs of operating GME programs should be defined broadly:

> Net costs of approved educational activities are determined by deducting, from a provider's total costs of these activities, revenues it receives from tuition. For this purpose, a provider's total costs include trainee stipends, compensation of teachers, *and other direct and indirect costs of the activities* as determined under the Medicare cost-finding principles in § 413.24.

42 C.F.R. § 413.85(g) (emphasis added).

The Medicare cost-finding principles set forth at 42 C.F.R. § 413.24 reinforce the conclusion that allowable educational costs are to be defined broadly. That regulation, which specifies the methods for identifying allowable Medicare costs from accounting records kept in connection with a provider's services, defines "cost-finding" as "the determination of [the cost of a particular service] by the allocation of direct costs and *proration of indirect costs*." 42 C.F.R. § 413.24(b)(1) (emphasis added).

In the preamble to final regulations issued in 1989 related to the determination of GME costs, the Secretary stated that such costs include a variety of overhead and administrative costs related to the operation of a GME program:

> The allowable costs of [graduate medical education] activities include the direct costs of salaries and fringe benefits of interns and residents, salaries attributable to the supervisory time of teaching physicians, other teachers' salaries, and the indirect costs (that is, institutional overhead, for example, employee health and welfare benefits) that are appro-

priately allocated to the particular medical education cost center.

54 Fed. Reg. 40286 (Sept. 29, 1989).

Finally, it is clear that Medicare regulations allow the Hospital to claim the costs incurred by the Medical School in connection with the operation of the Hospital's GME programs, when the Hospital and the Medical School are related by common ownership.

> [C]osts applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

42 C.F.R. § 413.17(a). The Secretary has always so interpreted the regulations. Thus, in guidelines issued to private entities who administer the Medicare program (intermediaries), the Secretary identified certain costs incurred by related medical schools which could be included in a provider's GME costs, including costs of a medical library, physician office space and clerical support. *See* Intermediary Letter 78-7 ("IL 78-7") (64a). These costs normally would be incurred directly by a hospital that operated GME programs independently of a related medical school. *Id.*

There can be no dispute, and indeed the Secretary did not dispute below, that the Medicare statute and relevant regulations allow for the reimbursement of direct and indirect GME costs, including costs incurred by a related medical school, where those costs are incurred in support of a provider's GME programs. Here, the Secretary did not deny the Hospital's claim because medical school costs cannot be claimed for Medicare reimbursement. Rather, the Secretary's denial of the Hospital's request was based on the fact that the Hospital had not claimed

these costs in periods prior to 1985. From this lone fact, the Secretary conclusively presumed that the costs at issue had previously been borne by the community and that the Hospital's claim for reimbursement constituted an impermissible "redistribution" of costs from an educational unit. In support of her decision, the Secretary relied on 42 C.F.R. § 413.85(c), which provides:

> It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the [Medicare] program will participate appropriately in the support of these activities. Although *the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from eductional institutions or units to patient care institutions or units.*

(Emphasis added).

Despite the regulation's clear reference to support for educational "activities," the Secretary and the courts below interpreted the regulation to mean that any *costs* not previously claimed by a provider had been forever waived. (19a). According to the Secretary and the courts below, if the costs had not been claimed from the beginning of the provider's participation in the Medicare program, they presumptively had been borne by the "educational unit" (which the Secretary equated with the community), and any attempt later to identify the costs for Medicare reimbursement constitutes a prohibited "redistribution." 21a-22a).

Here, the Hospital is the operator of GME programs and the formal education of residents takes place within its facilities. (8a, 17a). The supervision and education of the residents, however, are performed by the Medical

School's faculty members who are supported, administratively, by the Medical School in this task. (39a). For a number of years, the Hospital has claimed reimbursement for the proportionate share of faculty salaries and fringe benefit costs attributable to GME teaching efforts and other hospital administrative duties. (9a). These amounts were determined through the use of activity reports completed by faculty members on a biannual basis. (9a). Since 1974, the amount of claimed salary and fringe benefit costs associated with the GME programs and with hospital administration had always been allowed by the intermediary and is not at issue here. (8a). Although the system for determining the extent of costs attributable to GME teaching efforts originally was designed to be as accurate as possible, beginning in 1984 and continuing in its 1985 cost year, the Hospital undertook to refine its cost-finding techniques to ensure that all of the costs properly attributable to the operation of GME programs were identified and claimed for reimbursement. (9a). Thus, in 1985, the Hospital engaged a national accounting firm to conduct a cost study to identify all of the Medical School costs incurred in support of the Hospital's GME programs, in addition to the costs of faculty salaries and fringe benefits. (9a).

The 1985 cost study identified two categories of costs: the IL 78-7 costs (*i.e.*, costs related to faculty support) and indirect costs (*i.e.*, Medical School overhead costs, such as general and administrative costs that support general departmental functions of the Medical School and that are a necessary function of the GME programs). (40a). The cost study was the basis for the Hospital's 1985 claim for reimbursement and resulted in an increased claim for GME and Medical School faculty administrative costs over previous years' claims. (9a-10a).

The Hospital's 1985 request for additional GME program reimbursement was denied by the fiscal intermediary, an agent of the Secretary with responsibility for reviewing provider requests for Medicare reimbursement.

(10a). The Hospital then appealed to the PRRB, a tribunal within the Department of Health and Human Services, composed of five individuals knowledgeable in the field of medical cost reimbursement. (7a). The PRRB reversed the intermediary's decision and allowed reimbursement of the full costs documented in the cost study. (56a). The PRRB agreed with the Hospital that the cost study complied with the full costing requirements of 42 C.F.R. §§ 413.24 and 413.85(g) by identifying the total allowable costs incurred by the Medical School in support of the Hospital's GME activities, including direct and indirect costs. Accordingly, the PRRB found that the intermediary's disallowances were improper and that the Hospital should be permitted to claim the full amounts of GME and physician administrative costs documented by the cost study. (60a).

The PRRB specifically rejected the intermediary's argument that the cost study resulted in a redistribution of costs from the Medical School to the Hospital.

> [H]istorically, the provider has always utilized the services of faculty members of its related medical school for the supervision and education of the residents in its GME programs. Throughout its participation in the Medicare program, the provider has claimed the costs identified with these educational activities, and there is no evidence that the Intermediary ever disallowed the amounts claimed. . . . In 1985, the Provider performed an in-depth study of its GME programs in order to identify all costs related to its ongoing educational activities, and the fact that the provider did not fully identify all of the costs associated with its GME programs in prior years does not prohibit the correction of this error in the cost reporting period in contention.

(58a).

Upon review, the Secretary, acting through her agent, the Administrator of HCFA, reversed that portion of the PRRB decision that had allowed reimbursement for addi-

tional GME costs. The Administrator reasoned that since these costs had not been claimed by the Hospital in earlier cost years, they presumptively constituted a "redistribution" of costs previously borne by the "community" (here, the Medical School) to the Hospital. (34a-35a).

The Hospital timely appealed the Secretary's determination to the United States District Court for the Eastern District of Pennsylvania. There, on cross motions for summary judgment, the court determined that the Secretary's interpretation of the community support and redistribution principles of section 413.85(c) were reasonable and entitled to deference. (24a).

The district court's Memorandum and Order was filed on May 1, 1992. On June 22, 1992, the Hospital timely appealed the district court's decision to the court of appeals. In a judgment entered on April 21, 1993, the court of appeals affirmed, without opinion, the district court's decision.

REASONS FOR GRANTING THE WRIT

I. THE THIRD CIRCUIT'S JUDGMENT SHOULD BE REVIEWED BECAUSE IT CONFLICTS WITH THE DECISION OF THE SIXTH CIRCUIT INTERPRETING THE SAME REGULATION

The Third Circuit's judgment affirming the district court's decision here should be reviewed because it is directly contrary to a decision of the United States Court of Appeals for the Sixth Circuit, interpreting the same regulation under virtually identical circumstances. Without this Court's review, the conflicting results in these two cases will stand, and administration and interpretation of this important aspect of the Medicare program will in the future depend on the fortuity of where a hospital is located. This is more than a merely hypothetical concern. There is currently at least one case pending before the United States Court of Appeals for the Eighth Circuit raising this exact issue. *University of Minnesota Hospital and Clinic v. Shalala,* Dkt. No. 93-2420. Moreover,

Petitioner's counsel is aware of several cases at various stages of the administrative appeal process which also present the issue of the proper interpretation and application of section 413.85(c).

This case is virtually identical to *Ohio State University v. Sullivan,* 777 F. Supp. 582 (S.D. Ohio 1991), *aff'd,* —— F.2d —— (6th Cir. 1993) (67a). A comparison of this case with *Ohio State University* reveals the complete inconsistency of the results. In both cases, the hospital/providers are teaching hospitals operated by a university that also operates a related medical school. *Compare Thomas Jefferson University v. Sullivan,* No. 90-2036, slip op. (E.D. Pa. May 1, 1992) (at 8a), *with Ohio State University,* 777 F. Supp. at 583. Historically, neither hospital claimed costs associated with GME programs incurred by related medical schools other than faculty salaries. *Compare Thomas Jefferson University,* at 9a, *with Ohio State University,* 777 F. Supp. at 583. In 1985, each hospital undertook a study to determine whether the hospital was recouping all costs permitted by law. The result of the studies was a determination by both hospitals that all GME costs were *not* being reported and claimed. *Compare Thomas Jefferson University,* at 10a, *with Ohio State University,* 777 F. Supp. at 583. Both hospitals then submitted cost reports seeking reimbursement for additional costs associated with operation of their GME programs.

In both cases, the hospitals' intermediaries denied the reimbursement claim, the PRRB reversed the intermediaries, and the Administrator reversed the PRRB. *Compare Thomas Jefferson University,* at 10a-11a, *with Ohio State University,* 777 F. Supp. at 583-84. Both hospitals then appealed to the appropriate district court. There the paths of the cases diverge.

The Secretary made the same arguments in both cases. The Secretary justified her action based on the determination that there had been "redistribution" of costs from an educational institution (the medical schools) to a

patient care institution (the hospitals) in violation of 42 C.F.R. § 413.85(c). *Compare Thomas Jefferson University*, at 14a, *with Ohio State University*, 777 F. Supp. at 584. In order to determine that the GME costs claimed were "redistributed," the Secretary presumed that since costs had not previously been claimed by the hospitals, the costs must have been borne by the medical schools (which in *Thomas Jefferson University*, the Secretary equated with the "community"). *Compare Thomas Jefferson University*, at 19a, *with Ohio State University*, 777 F. Supp. at 586.

In *Ohio State University*, the district court found this interpretation was unreasonable. The court pointed out that the statutory and regulatory scheme suggests that redistribution refers to *activities*, not costs. 777 F. Supp. at 586. The court also noted that the "related organizations principle" allowed for payment of costs incurred by a related organization, as though they were incurred by the hospital. *Id.* at 588. In *Thomas Jefferson University*, on the other hand, the district court, looking at these same regulations and a virtually identical factual record, found reasonable the Secretary's determination that the request for GME program costs was a prohibited redistribution. (24a) .

The losing party in both cases appealed. In this case, the Third Circuit simply affirmed, without opinion, the district court's decision, apparently adopting the reasoning of the lower court regarding the Secretary's interpretation of section 413.85(c). *Thomas Jefferson University v. Shalala*, No. 92-1513 (3d Cir. April 21, 1993) (1a). The Sixth Circuit also affirmed the *Ohio State University* trial court. *Ohio State University v. Secretary of Health & Human Services*, —— F.2d —— (6th Cir. 1993) (67a). In its opinion, the court agreed that the Secretary's interpretation of 42 C.F.R. § 413.85(c) was unreasonable and unpersuasive. (71a).

Thus, on virtually identical facts, two different courts of appeals have reached directly contrary results. Such confusion in the administration of a statutory scheme as important as the Medicare program is unacceptable. Only intervention by this Court can resolve the conflict and ensure that future cases are uniformly decided.

II. THE INTERPRETATION OF SECTION 413.85(c) BY THE SECRETARY AFFIRMED BY THE COURTS BELOW IS ARBITRARY, CAPRICIOUS AND UNSUPPORTED BY SUBSTANTIAL EVIDENCE

The Secretary denied the Hospital's claim on the ground that the reimbursement sought constituted redistribution of *costs* from the Medical School to the Hospital. In short, the Secretary created an irrebuttable presumption that unless costs had previously been claimed by the Hospital for reimbursement, they were being redistributed. (35a). *See also* 777 F. Supp. at 588. According to the Secretary, this result is mandated by section 413.85(c) which provides that:

> Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

The Secretary interprets section 413.85(c) to mean that the *costs* at issue must have been "customarily and traditionally" claimed by the hospital. As a reading of the regulation makes clear, however, and as the courts in *Ohio State University* found, the prohibition against redistribution is contained in a sentence that begins, "the intent of the program is to share in the support of educational *activities* customarily or traditionally carried on by providers. . . ." 42 C.F.R. § 413.85(c) (emphasis added). The clear meaning of this passage is that the

program will pay for costs of activities traditionally carried on by hospitals (*e.g.*, clinical training of residents and interns), but that it will not pay for activities (*e.g.*, classroom training) traditionally carried on by educational institutions. *See Ohio State University*, 777 F. Supp. at 586 ("It is the activities which must be customary and traditional, not the provider's practice of paying for them or claiming reimbursement for them.").

That this is the proper interpretation of section 413.85(c) is evidenced by the Secretary's own actions, both with respect to her past treatment of the Hospital and her past and current interpretations of the redistribution language. In the instant case, the record is clear that the Hospital had GME program costs long before the Medicare program began. (*See* 8a). The Hospital began participating in Medicare at the program's inception in 1966 (*id.*); it did not begin claiming Medical School faculty salary costs for its GME programs until 1974. *Id.* If the Secretary's interpretation of section 413.85(c) is correct, of course, the Hospital's initial claim for reimbursement of GME costs in 1974 was a "redistribution," since, at that time, the Hospital had not "historically" claimed such costs. The Secretary did not make such a claim in 1974 with regard to Thomas Jefferson University, nor, prior to the mid-1980s, did she ever claim that any teaching hospital claiming GME costs for the first time, or simply claiming *increased* costs, was engaged in a "redistribution." Indeed, her internal operating guidelines issued to provide guidance to teaching hospitals for claiming costs incurred by a related medical school recognizes as "allowable hospital costs" the reasonable costs incurred by a related medical school in support of the hospital's GME programs. IL 78-7 (64a). Nowhere does IL 78-7 suggest that these cost claims must meet the Secretary's redistribution analysis. Nor does IL 78-7 suggest that teaching hospitals can claim as related party medical school costs only those costs which they have historically claimed. It is remarkable that neither

the concept of redistribution nor the relevant regulatory section is cited in the Secretary's internal guidelines for the proper treatment of GME costs by teaching hospitals. This absence is persuasive evidence that the Secretary's interpretation of section 413.85(c) is *not* a long-standing or consistent policy, but rather a recently-discovered tool for denying legitimate reimbursement claims.

This conclusion is further supported by the Secretary's recent rulemaking activity in this area. In 1992, the Secretary promulgated proposed regulations to amend section 413.85(c). *See* 57 Fed. Reg. 43659, 43672 (Sept. 22, 1992). In her proposed regulations, the Secretary acknowledges that the Agency has not previously provided any criteria for determining whether there has been "community support" for GME programs. 57 Fed. Reg. at 43661. Her proposed regulation does indeed purport to establish prospectively "community support" from failure to claim a cost in the past. However, the Secretary's acknowledgement that previously no such criteria existed is powerful proof that application of this presumption to the Hospital is arbitrary and capricious. If the Secretary's proposed regulations go into effect, she would, of course, be prohibited by this Court's decision in *Bowen v. Georgetown University Hospital*, 488 U.S. 204 (1988), from applying the regulation to Petitioner retroactively.

The same argument applies to the Secretary's "redistribution" argument. In her proposed regulations, the Secretary offers the following criteria for determining whether a claimed cost is a prohibited redistribution:

> Redistribution of costs is defined as an attempt by a provider to increase the amount, or to expand the types, of the costs of educational activities that are allowed for Medicare payment purposes by claiming costs that previously were not claimed by the provider and were considered costs of an educational institution. For example, costs for a school of nursing or allied health education that were incurred by an educational institution rather than the provider in its

> prospective payment or rate-of-increase limit base year cost report are not allowable costs in subsequent fiscal years.

57 Fed. Reg. at 43672.

Plainly, the Secretary seeks here to apply retroactively rules that she is just now promulgating. This "back door" attempt at retroactive rulemaking violates the spirit of *Georgetown* and is just as unlawful as the actual attempt there to engage in retroactive rulemaking.

The Secretary's apparent determination that regulations spelling out the criteria for determining "community support" and "redistribution" were required is further evidence that no such definitions or criteria existed previously. The Secretary's attempt to apply these definitions to the Hospital when, at the time the cost claims were made, there was no notice to the Hospital of the Secretary's interpretation of the regulation, is arbitrary and capricious.

The policy of the Medicare Act is clear. Congress sought to provide a system of medical insurance for the aged and disabled. The system designed provided that providers of medical services were to be reimbursed for their reasonable costs of furnishing needed health services to covered beneficiaries. The Secretary's decision here, affirmed by the courts below, that certain costs cannot be reimbursed because they were not claimed from the inception of the Medicare program, is flatly inconsistent with the basic purpose of the statute.

III. THE DECISION BELOW INTERPRETS SECTION 413.85(c) IN A MANNER INCONSISTENT WITH THE MEDICARE STATUTE

In promulgating the Medicare Act in 1965, Congress made clear its intent that Medicare providers were to be reimbursed, as nearly as possible, for all costs necessarily incurred in the efficient delivery of health care services

to Medicare beneficiaries. The Senate Report accompanying the Medicare Act states Congress' explicit intent:

> Although [reimbursement] may be made on various bases the objective, whatever method of computation is used, will be to approximate as closely as practicable the actual cost (both direct and indirect) of services rendered to the beneficiaries of the program so that under any method of determining costs, the costs of services of individuals covered by the program will not be borne by individuals not covered, and the costs of services of individuals not covered, will not be borne by the program.

S. Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S.C.C.A.N. 1943, 1976. This expression of Congressional purpose is codified in the Act where the Secretary is directed to issue regulations for determining reasonable costs under the Medicare program. 42 U.S.C. § 1395x(v)(1)(A). There, Congress directed that the Secretary's regulations

> *shall* . . . take into account both direct and indirect costs . . . in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by [Medicare] will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by [Medicare].

Id. (emphasis added).

The result of the Third Circuit's judgment affirming the district court decision here is exactly contrary to Congressional intent: it shifts the costs of providing services to Medicare beneficiaries to individuals not covered by the program. *See Ohio State University*, 777 F. Supp. at 587 ("If the Medicare program did not pay its fair share of [GME program] costs, there is a likelihood that they would be shifted to non-Medicare patients in violation of the Medicare Act, 42 U.S.C. § 1395x(v)(1)(A) . . ."). Such a result is contrary to the meaning and purpose of the Medicare Act, and should not be allowed to stand.

CONCLUSION

For the foregoing reasons, Petitioner respectfully prays that the Court issue a writ of certiorari to review the judgment of the Court of Appeals for the Third Circuit.

Respectfully submitted,

H. GUY COLLIER
Counsel of Record
AMY E. HANCOCK
MCDERMOTT, WILL & EMERY
1850 K Street, N.W.
Suite 500
Washington, D.C. 20006
(202) 887-8000

JAMES M. GAYNOR, JR.
MCDERMOTT, WILL & EMERY
227 West Monroe Street
Chicago, Illinois 60606
(312) 372-2000
Counsel for Petitioner

Dated: July 20, 1993

APPENDICES

APPENDIX TABLE OF CONTENTS

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 92-1513

THOMAS JEFFERSON UNIVERSITY,
a Pennsylvania not-for-profit corporation
dba THOMAS JEFFERSON UNIVERSITY HOSPITAL

v.

DONNA SHALALA,
SECRETARY OF HEALTH AND HUMAN SERVICES [1]

THOMAS JEFFERSON UNIVERSITY,
Appellant

Appeal from the United States District Court
for the Eastern District of Pennsylvania
(D.C. Civil No. 90-02036)
District Judge: Honorable William J. Yohn, Jr.

Submitted Under Third Circuit Rule 12(6)

April 19, 1993

Before: MANSMANN, ALITO and ALDISERT,
Circuit Judges

---

[1] At the time the Final Order of the Secretary of Health and Human Services was issued Louis Sullivan, M.D., served as the Secretary of Health and Human Services. We have changed the caption to reflect automatic substitution of the named public officer pursuant to Fed. R. App. P. 43(c).

JUDGMENT ORDER

After consideration of all contentions raised by the appellant, it is

ADJUDGED AND ORDERED that the judgment of the district court be and is hereby affirmed.

Costs taxed against the appellant.

BY THE COURT

/s/ Carol L. Mansmann
Circuit Judge

Attest:

/s/ P. Douglas Sisk
P. DOUGLAS SISK
Clerk
Apr. 21, 1993

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE
EASTERN DISTRICT OF PENNSYLVANIA

Civil Action 90-2036

THOMAS JEFFERSON UNIVERSITY
d/b/a THOMAS JEFFERSON UNIVERSITY HOSPITAL

v.

LOUIS W. SULLIVAN, M.D., Secretary,
DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEMORANDUM AND ORDER

Yohn, J. May 1, 1992

The dispute in this case concerns the reimbursement due to Thomas Jefferson University Hospital ("TJUH" or "Hospital") for fiscal year 1985 pursuant to the provisions of Title XVIII of the Social Security Act ("Act"). The Act established the federally funded health insurance program for the elderly and disabled known as Medicare. 42 U.S.C. § 1395 et seq.

This matter is before the court on appeal from the final decision of the Health Care Financing Administration ("Administrator") acting on behalf of the Secretary of Health and Human Services ("Secretary"), denying the Hospital's claim for reimbursement of the full costs of faculty salaries and fringe benefits, the salaries and fringe benefits of the faculty's support staff and facilities costs

incurred in connection with the operation of graduate medical education ("GME") programs at the Hospital as well as indirect administrative costs for the services of other personnel affiliated with the Thomas Jefferson University College of Medicine ("Medical School"). The claimed costs in dispute total $2,861,247 of which $2,431,244 are associated directly with the GME programs, while $430,003 are related to the indirect administrative costs.[1]

The parties agree that no genuine issues of material fact exist in connection with this appeal and invite the court to resolve the dispute based upon their cross motions for summary judgment. For the reasons stated herein, the court will grant summary judgment in favor of the Secretary and deny summary judgment for the Hospital.

BACKGROUND

A. The Medicare Program

1. *Program Objectives and General Principles of Cost Reimbursement*

Congress established the Medicare program as a means to provide health insurance benefits to the elderly and disabled. The program is divided into two parts. Part A, known as the "health insurance program," provides insurance for inpatient hospital and related post-hospital services. 42 U.S.C. §§ 1395(c), 1395(d). Part B establishes a voluntary program of "supplementary medical insurance" covering physicians' charges and other medical services. 42 U.S.C. §§ 1395k, 13951 and 1395x(s). Medicare beneficiaries are entitled to receive medical services at any facility participating in the Medicare program as a "provider of services." 42 U.S.C. §§ 1395(d), 1395x(b). It is uncontroverted that the Hospital is an approved Medicare provider.

[1] At oral argument on the motions, counsel for the Hospital stated that the direct GME program costs in dispute ($2,431,244) are comprised of direct faculty salaries and fringe benefits, salaries and fringe benefits of the faculty's clerical staff and space costs. The indirect administrative costs in dispute ($430,003) represent expenses incurred by the Medical School in connection with such activities as admissions and general management of the GME program. As examples of these administrative costs the Hospital cited expenses associated with selecting residents and interns and costs incurred by the dean's office in administering the GME program.

From 1966 through 1982, Medicare reimbursed providers for "reasonable costs" incurred in delivering covered services to program beneficiaries. Reasonable cost was defined as the "cost actually incurred," exclusive of those costs "found to be unnecessary in the efficient delivery of needed health services." 42 U.S.C. § 1395x(v). This system of reimbursement provided no incentive for providers to promote efficient and cost-effective delivery of patient care. Rather, over the years the system created a pattern of reimbursement that responded to increased costs by simply providing increased reimbursement.

Recognizing the urgent need to stem the spiraling costs associated with the Medicare program as well as to promote efficiency, Congress included within the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA") provisions that imposed a ceiling on the rate of increase of inpatient operating costs recoverable by a provider. The Medicare reimbursement system was reformed further in 1983 when Congress enacted legislation providing for reimbursement of Medicare providers based upon the Prospective Payment System (PPS). The PPS is designed to enhance the Medicare program's ability to act as a prudent purchaser of services and to provide increased predictability respecting program costs. H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983), *reprinted in* 1983 U.S. Code Cong. & Admin. News 219, 351.

The PPS established fixed rates for reimbursement of costs associated with the inpatient care of program beneficiaries. Direct and indirect costs incurred in connection

with graduate medical education, however, were expressly excluded from the reimbursement system implemented under the PPS. Instead, GME costs continued to be reimbursed on the basis of reasonable cost. *Id.* at 359; 42 U.S.C. § 1395ww(h). By excluding GME costs from the PPS, however, Congress did not intend to exempt such costs completely from a system of control designed to improve predicability and neutralize cost increases. Nor did Congress intend that providers should be permitted to redistribute costs among program areas to maximize the level of reimbursement available from Medicare.

2. *Administration of the Medicare Program*

Congress delegated administration of Medicare's reimbursement system to the Secretary, in which capacity he may promulgate such regulations as are necessary to govern payments to providers. 42 U.S.C. § 1395x(v)(1)(A). In addition, from time to time the Secretary may issue interpretations of governing statutes and regulations which are collected in the Medicare Provider Reimbursement Manual.

To qualify for reimbursement under the program, providers such as the Hospital enter into agreements with the Secretary to provide services to Medicare beneficiaries. The Secretary then contracts with fiscal agents known as intermediaries to assist with program reimbursement. 42 U.S.C. § 1395(h). Intermediaries, acting as the Secretary's agents, review cost reports submitted by providers at the end of each fiscal year to make a final determination of the amount of reimbursable costs. 42 U.S.C. § 1385(g); 42 C.F.R. §§ 413.20(b), 413.24(f), 413.60. For the fiscal year at issue in this case, 1985, Aetna Life Insurance Company served as the government's fiscal intermediary for purposes of auditing the Hospital's claim.

Although the Medicare reimbursement scheme is complex, for purposes of this appeal, it can be viewed as consisting of two steps. The first step requires an identification of those costs that are "reasonable, necessary and related to patient care" furnished to both Medicare and non-Medicare patients. In essence, this step establishes the allowability of costs. The second step of the reimbursement process requires apportionment of allowable costs between Medicare and non-Medicare patients. 42 C.F.R. § 413.1 et seq. The dispute in this case centers on step one of the reimbursement process, the allowability of costs.

3. *Review of Decisions Affecting Reimbursement*

Once the fiscal intermediary has analyzed the cost report submitted by a provider, a written notice of program reimbursement is prepared setting forth the total amount of reimbursement due under the program. 42 C.F.R. § 405.1803. The notice explains how the determination respecting allowable and reimbursable costs was reached, relates the determination to the provider's claimed reimbursement and advises the provider of its right to appeal. A provider dissatisfied with the determination of the intermediary may, within 180 days, request a hearing before the Provider Reimbursement Review Board ("PRRB" or "Board"), a tribunal within the Department of Health and Human Services charged with exclusive jurisdiction over Medicare reimbursement claims. 42 U.S.C. § 1395oo.

The PRRB, composed of five individuals knowledgeable in the field of medical cost reimbursement, is appointed by the Secretary. Pursuant to the requirements of the Act, the Board must be comprised of two members representative of Medicare service providers. 42 U.S.C. § 1395oo(h). At least one member of the Board must be a certified public accountant. *Id.*

Where a provider requests and receives a Board decision in connection with a challenge to a reimbursement determination, the Secretary, acting through the HFCA Adminis-

trator, may reverse, affirm or modify the Board's decision. 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1875. A provider may seek judicial review of the Secretary's final decision by means of a civil action commenced within 60 days of the date on which notice of the final decision is received. 42 U.S.C. § 1395oo(f)(1). It is undisputed that the Hospital has perfected its right to appeal and that this court properly may take jurisdiction over the matter.[2]

B. Factual Summary

Thomas Jefferson University Hospital is a 700-bed teaching hospital operated by Thomas Jefferson University, a private not-for-profit educational institution. A.R. at 26. The University was formed in 1824; an infirmary was opened the following year. A.R. at 40. In 1877, the University established a hospital facility that has been in continuous operation since that time. *Id.* The University also includes a College of Medicine, an Allied Health School and a Graduate School. A.R. at 11.

The Hospital operates graduate medical education ("GME") programs for its interns and residents in a wide variety of medical specialties. A.R. at 40. GME programs are conducted in the Hospital by faculty of the College of Medicine. A.R. at 13. Although the Hospital became an approved provider at the inception of the Medicare program in 1966, the first claim for reimbursement was not submitted until 1974. Since 1974, however, the Hospital has claimed and the intermediary has allowed reimbursement for costs associated with its GME programs. A.R. at 41.

[2] The court notes that plaintiff has failed to establish in any of the pleadings filed in this matter the date upon which notice of the Secretary's final decision was received. Defendant, however, agrees that this appeal was timely filed. *Def's. Motion for Summary Judgment*, at 18. The court will, therefore, order the plaintiff to file an affidavit stating the date upon which notice of the final decision was received for purposes of completing the record.

Between 1974 and 1983, the Hospital claimed Medicare reimbursement for three categories of costs reimbursable on a reasonable cost basis: 1) salaries paid directly by the Hospital to faculty of the Medical School for services rendered in the Hospital; 2) salaries paid directly to residents; and 3) funds transferred from the Hospital to the Medical School as payment for faculty time expended on GME program activities ("professional salaries"). A.R. at 137. Faculty time devoted to the Hospital's GME program is documented by means of a personal activity report (PAR) completed by each participating physician at six month intervals. A.R. at 137. The PARS form the basis for calculating the amount of professional salaries properly charged to the Hospital. The Hospital reimburses the Medical School for these salaries by means of an internal transfer of funds. A.R. at 138.

Coincident with the implementation in 1984 of the PPS, the Hospital undertook to review its claim for costs associated with the GME programs to determine whether it was identifying properly all costs eligible for reimbursement under the applicable policies and regulations. A.R. 143, 1239. This review resulted in an increased claim reflecting clerical costs incurred by the Medical School for activities identifiable to the GME program.[3] In 1985, in an effort to refine further its cost finding techniques, the Hospital engaged an accounting firm to conduct a study ["Cost Study"] intended to form the basis for the fiscal year 1985 reimbursement claim.

At the time the Hospital submitted its claim for GME costs incurred in fiscal year 1985, the Cost Study had not yet been completed. Anticipating that the Cost Study would substantiate an increase in reimbursable GME program costs, however, the Hospital simply increased the resident and intern costs of $4,737,219 by $4,000,000

[3] The intermediary allowed these clerical costs, but subsequently determined that such allowance was in error. A.R. at 51.

resulting in a claim of $8,737,219. A.R. at 154. The Hospital also claimed an additional $2,032,380 in indirect costs incurred by the Medical School in connection with administration of GME programs it believed would be supported by the Cost Study.

Upon initial audit of the Hospital's fiscal year 1985 claim, the intermediary allowed reimbursable costs of $5,944,958 consisting of $4,183,480 for direct GME program support and $1,761,478 for the indirect administrative costs. This amount was derived by applying an inflation factor to costs claimed by the Hospital in fiscal year 1984. The intermediary and the Hospital agreed that the question of total allowable costs for fiscal year 1985 would be revisited upon completion of the Cost Study. A.R. at 145.

The Cost Study, when completed, supported GME program costs of $6,614,724 and indirect administrative costs of $2,191,481 for a program total of $8,806,205. Although the intermediary audited the Cost Study in the spring of 1986, it nonetheless declined to reimburse the Hospital for costs documented therein alleging that the Cost Study represented an improper attempt to redistribute costs from an educational unit to a hospital unit in violation of 42 C.F.R. § 413.85.

The table below details the costs in dispute.

	Graduate Medical Education Costs	Administrative Costs	Total
Estimated Amounts Claimed by Hospital on Cost Report	$8,737,219	$2,032,380	$10,769,599
Amounts Supported By Cost Study	$6,614,724	$2,191,481	$ 8,806,205
Amounts Allowed By Intermediary	$4,183,480	$1,761,478	$ 5,944,958
Allowable Amounts in Dispute	$2,431,244	$ 430,003	$ 2,861,247

A.R. at 27.

C. Procedural History

The Hospital timely appealed to the PRRB the intermediary's decision respecting reimbursable costs. As framed by the Board, the question presented for review was the propriety of the intermediary's adjustments disallowing portions of the medical education costs claimed by the Hospital. A.R. at 26. Upon completion of an evidentiary hearing and post-hearing briefing by the parties, the PRRB reversed the intermediary's decision and allowed reimbursement of the full costs documented by the Cost Study. A.R. 25-29.

Upon review, the Administrator modified the decision of the PRRB, declaring that the Hospital was entitled to reimbursement only for "those medical education costs which it had traditionally claimed and been allowed prior to 1984." A.R. at 9.[4]

The Hospital timely filed this appeal from the Administrator's final decision seeking an order that the Secretary provide reimbursement for the full actual costs of the GME programs as well as the full actual costs related to administration of hospital departments. In the alternative, the Hospital seeks enforcement of the Secretary's decision that it is entitled to reimbursement for costs traditionally claimed and allowed, a decision the Hospital asserts entitles it to an additional $1,297,044.[5]

---

[4] The Medicare Provider Reimbursement Manual states that "[t]he traditional practice followed in the past with respect to types of services rendered and the cost related thereto between providers and educational institutions shall be followed." Provider Reimbursement Manual at § 406.

[5] At oral argument, the Secretary conceded that the final decision issued in this matter failed to challenge or modify the PRRB's determination that the Hospital was entitled to the full allowable costs associated with direct faculty salaries and fringe benefits incurred in connection with the GME program as well as physician administrative services. Therefore, despite the fact the claim for reimbursement submitted in fiscal year 1985 reflected increased

D. Standard of Review

Jurisdiction to review the Secretary's final decision in a Medicare dispute is conferred upon this court by 42 U.S.C. § 1395oo(f)(1), which incorporates the standards of the Administrative Procedure Act, 5 U.S.C. §§ 551-59, and 701-06. *Monsour Medical Center v. Heckler*, 806 F.2d 1185 (3d Cir. 1986), *cert. denied*, 482 U.S. 905 (1987). Section 706 permits the court to set aside an agency's action, findings and conclusions only if they are found to be "arbitrary, capricious, and abuse of discretion or otherwise not in accordance with law . . . [or] unsupported by substantial evidence." 5 U.S.C. § 706(2)(A)-(E). Substantial evidence is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 477 (1951).

A district court, when exercising its powers of review under section 706, must accord substantial deference to the interpretation applied by the agency charged with administration of a statute or regulation. *Chevron U.S.A., Inc. v. Natural Resources Defense Council*, 467 U.S. 837 (1984). Such deference is especially appropriate where the agency's interpretation is necessary to resolve issues raised in the context of a complex scheme of reimbursement. *Monongahela Valley Hosp., Inc. v. Sullivan*, 945 F.2d 576, 591 (3d Cir. 1991) (citations omitted). Moreover, as the *Chevron* Court observed, when Congress expressly delegates to an agency authority to fill gaps in a statute, the regulations promulgated "are given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute." *Id.* at 844. *Accord Sacred Heart Medical Center v. Sullivan*, 1992 U.S. LEXIS 3796 at *21 (3d Cir. Mar. 9, 1992).

---

costs, the Secretary has entered into a stipulation with the Hospital pursuant to which these particular costs will be reimbursed. Consequently, the court need not address the Hospital alternative argument respecting reimbursement.

The court is mindful, then, in undertaking a review of the Secretary's decision, that its role in this process "is not to impose its own interpretation of the . . . regulation[s], but instead to defer to [the Secretary's] position so long as it is reasonable." *Monsour Medical Center*, 806 F.2d at 1191. Consequently, if the court finds the Secretary's interpretation reasonable, it will not be disturbed on appeal.

DISCUSSION

A. *The PRRB Decision*

In reaching its decision in favor the Hospital, the PRRB found that the Cost Study was prepared in compliance with applicable regulations and was, therefore, a valid and accurate statement of reimbursable costs. A.R. at 37. In addition, the Board concluded that the Study represented a refinement of the Hospital's methodology for determining costs associated with the GME program and rejected the intermediary's position that the Study was calculated to redistribute costs improperly from the Medical School to the Hospital. The Board opined that "[t]he fact that the Provider did not fully identify all of the costs associated with its GME programs in prior years does not prohibit the correction of this error in the cost reporting period in contention." A.R. at 38.

Finally, the Board found that the Cost Study did not result in redistribution to the Medicare program of costs previously borne by the community. Rather, the Board concluded, the record showed that the sole community support received by the University consisted of appropriations from the Commonwealth of Pennsylvania and the State of Delaware. A.R. at 38. In addition, the evidence established that these appropriations were earmarked specifically for the support of undergraduate medical education. *Id.* The Board determined that such a limitation plainly precluded a finding that these appropriations constituted community support for GME programs. A.R. at 39.

Contrary to the position taken by the Board, the Administrator found that "the Provider improperly tried to redistribute costs traditionally borne by the community, i.e., the university medical school, in violation of the regulation at 42 C.F.R. § 413.85(c) and Congressional intent." A.R. at 8.

B. Reimbursement for Costs Associated with Educational Activities

Reimbursement under the Medicare program for educational activities is governed by the regulation set out at 42 C.F.R. § 413.85(c) which states:

> *Educational activities.* Many providers engage in educational activities including training programs for nurses, medical students, interns and residents and various paramedical specialties. These programs contribute to the quality of patient care within an institution and are necessary to meet the community's needs for medical and paramedical personnel. It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until those communities undertake to bear these costs, the program will participate appropriately in the support of these activities. Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

It is widely accepted that this regulation reflects express Congressional intent that the Medicare program should share in the costs of graduate medical education to the

extent that such activities enhance the quality of patient care and are not borne by the community. *See* S. Rep. No. 404, 89th Cong., 1st Sess. (1965), *reprinted in* 1965 U.S. Code Cong. & Admin. News 1943, 1977. *See also, St. John's Hickey Memorial Hosp. v. Califano,* 599 F.2d 803, 808 (7th Cir. 1979) (Congress plainly evidenced its intent that educational activities designed to enhance patient care should be borne to appropriate extent by the Medicare program); *Ohio State Univ. v. Sullivan,* 777 F. Supp. 582 (S.D. Ohio 1991) (same); *Board of Trustees of State Insts. of Higher Learning v. Sullivan,* 763 F. Supp. 178, 184-85 (S.D. Miss. 1991) ("Mississippi") (same).

Adopting a plain meaning approach, the court finds that costs of educational activities incurred by a Medicare provider are eligible for reimbursement under the regulation if four criteria are satisfied: 1) the costs are incurred in connection with an approved program designed to deliver training to, among others, interns and residents; 2) the program contributes to the quality of patient care within an institution; 3) the costs associated with the program have not been borne traditionally by the community; and 4) the costs associated with the program have not been redistributed from an educational institution to a patient care unit.

In concluding that the Hospital was not entitled to the level of reimbursement claimed in connection with its GME program, the Administrator determined that the Hospital had run afoul of both the community support and the redistribution criteria. Specifically, the Secretary stated that

> In this case, the Provider has attempted to claim costs historically borne by the University Medical School. From 1974 to 1983, the Provider has been reimbursed for a proportionate share of the direct faculty compensation costs. The Provider has attempted to radically expand the types of costs

claimed by the provider for educational activities. . . . Evidence in the record shows that these cost[s] have been historically borne by the community. The Medicare program was enacted to provide a hospital insurance and basic protection against the costs of hospital care for the aged, and not intended to subsidize medical education programs already supported by the community.

Consequently, the Board improperly determined that the provider's failure to claim these costs in an earlier cost year was an "error," which it was just attempting to correct. Rather, that the Provider did not claim these costs in an earlier cost year is evidence of the communities [sic] support for these activities. To allow the community to withdraw its support and pass these costs to the Medicare program would result in a redistribution of costs in violation of 42 C.F.R. § 413.85(c).

A.R. at 7.

1. *Reimbursement Pursuant to 42 C.F.R. § 413.85(c)*

In reviewing the Secretary's application of the reimbursement criteria outlined above to the facts of this case, the court addresses preliminarily the Hospital's argument that the community support and redistribution principles articulated in 42 C.F.R. § 413.85(c) should apply only to the academic or "classroom" portions of the Hospital's training programs and not to clinical training programs. The court finds such an interpretation in conflict with the plain language of the regulation.

Specifically, although captioned "educational activities," a denomination which might suggest the regulation applies only to academic programs, section 413.85(c) makes clear that the regulation also governs reimbursement for educational activities directed toward interns and residents. Such training is predominantly, if not exclu-

sively, clinical in nature. In fact, the record in this case establishes that the training of interns and residents at TJUH takes place exclusively in the Hospital. A.R. at 133.

The regulation simply contains no language evidencing an intent to distinguish between academic and clinical training for purposes of determining the allowability of costs claimed. Moreover, the Provider Reimbursement Manual makes clear that section 413.85(c) applies to both clinical and classroom training activities. *See, e.g.*, Provider Reimbursement Manual § 404.2. Consequently, the court must reject the Hospital's invitation to narrow the universe of costs to which the community support and redistribution principles apply.

It is not disputed that the GME program operated at the Hospital is approved or that it contributes to the quality of patient care.

2. *The Community Support Issue*

The decision rendered by the Secretary in this matter relied, in part, upon the community support principle as a basis for denying the Hospital's request for reimbursement of the full costs supported by the Cost Study. In reviewing the Secretary's application of this principle, the court must resolve two issues: 1) whether the definition of community support applied by the Secretary is consistent with previous pronouncements and, therefore, entitled to deference; and 2) whether the regulation evidences an intent that Medicare support for educational activities should increase in an instance in which community support decreases.

The regulation governing reimbursement for costs incurred in connection with educational activities does not define community support. At oral argument, the Secretary stated that his definition of community support is based on commonsense as well as the principles of cost reimbursement promulgated by the American Hospital As-

sociation ("AHA"). In essence, the Secretary views community support as any source of funding other than the Medicare program.

The Secretary's decision in this case considered community support to include "tuition, hospital fees, grants, bequests, and state funded support from Pennsylvania and Delaware." A.R. at 5. The court finds such a definition reasonable and entitled to deference. In addition, the court concludes that the definition applied in this case is consistent with both the AHA principles as well as the Secretary's earlier applications of the community support principle in the context of disputed claims for reimbursement of GME program costs.

For example, in *University of Minnesota Hosps. & Clinics v. Blue Cross & Blue Shield Assoc.*, Medicare & Medicaid Guide (CCH) ¶ 39,420 at 26,828 (May 29, 1991), the Secretary announced that for purposes of applying 42 C.F.R. § 413.85(c), community support consisted of "tuition and fees, Federal appropriations, Federal grants and contracts, private gifts, grants and contracts, endowment income, investment income and other income." Similarly, in the proceedings connected with the *Mississippi* case, *supra*, the Secretary took the position that community support was comprised of "State appropriations, along with tuition revenues and grants." 763 F. Supp. at 190. Finally, the AHA appears to contemplate that tuition, scholarships, grants and other private contributions may be included within the universe of community support. *See Principles of Payment for Hospital Care* § 2.302. A.R. at 67.

Having determined that the definition of community support applied by the Secretary in this case is both reasonable and consistent with earlier pronouncements, the court turns its attention to question of whether the administrative record contains substantial evidence to support the Secretary's conclusion that the costs now claimed by

the Hospital have been borne historically by the community.

At the hearing convened by the PRRB, Mark Richards, then the Associate Vice President for Finance at TJUH, testified that sources of funding for the University included appropriations from the Commonwealth of Pennsylvania and the State of Delaware as well as gifts, grants and alumni giving endowments. A.R. at 132, 142. In addition, evidence presented before the Board established that prior to the time the costs at issue in this matter were included in the Hospital's claim for Medicare reimbursement, such costs were borne by the Medical School. A.R. at 209, 217-18, 328.

Based upon these facts as well as an examination of the record as a whole, the court concludes that the Secretary's finding that increased costs for graduate medical education claimed by the Hospital in the 1985 fiscal year had been borne traditionally by the community is supported by substantial evidence and is, therefore, adequate to support the conclusion that the increased costs claimed by the Hospital for fiscal year 1985 are not allowable. Therefore, this finding will not now be disturbed. In addition, the court finds persuasive, if not dispositive, the Secretary's argument that to the extent the Hospital has never before claimed the excess costs now at issue, despite the fact that they were incurred in previous years, it is reasonable to assume the community was bearing these costs.

The Secretary's reliance upon the community support principle as a basis for denying the level of GME program reimbursement claimed by the Hospital in fiscal year 1985 also requires the court to determine whether a provider may look to the Medicare program for increased support in an instance, such as that presented in this case, in which community support decreases. Based upon the plain language of 42 C.F.R. § 413.85 as well as the

legislative history accompanying the 1983 amendments to the Social Security Act, the court is unable to conclude that the Medicare program may be tapped as a source of increased support for costs historically borne by the community.

The regulation evidences Congress' express intent that the costs of medical educational programs should be borne by the community. Recognizing, however, that such support may be wanting, the regulation also provides that "*until* [] communities undertake to bear these costs, the [Medicare] program will participate appropriately in the support of these activities." 42 C.F.R. § 413.85(c) (emphasis added). Nothing in the regulation suggests, however, that a provider may seek to compensate for a decline in community support by escalating costs claimed from the Medicare program.

Moreover, in enacting sweeping revisions of the Social Security Act in 1983, primary among Congressional objectives were stemming the spiraling costs of the Medicare program to prevent exhaustion of the fund and achieving a level of budget neutrality. *See* 1983 U.S. Code Cong. & Admin. News at 351. Consequently, an interpretation of the regulation that results in a shifting of costs traditionally borne by another source to the Medicare program would plainly conflict with legislative intent. Finally, to the extent that Congress has not evidenced its support for increased Medicare funding as a means to close financial gaps created by declining community support, the Secretary's position that such cost shifting is impermissible is entitled to deference on review.

3. *The Redistribution Question*

In addition to invoking the community support principle to support his decision, the Secretary also relied on the prohibition against the redistribution of costs from an educational institution to a patient care institution as a basis upon which to deny the Hospital's claim for in-

creased costs. Specifically, the Secretary concluded that "the Provider improperly tried to redistribute costs traditionally borne by the community, i.e., the university medical school, . . . in violation of 42 C.F.R. 413.85(c) and Congressional intent." A.R. at 8.

At the threshold of this analysis, the court must reject the Hospital's argument that the redistribution principle operates to prohibit only the impermissible shifting of "activities" from an educational unit to a patient care unit and does not apply to the shifting of "costs" for activities customarily and traditionally carried on the provider. The Secretary asserts that the redistribution principle applies to both activities and costs. To interpret the regulation otherwise, the Secretary opines, would result in a system under which "all costs for pre-existing activities may be shifted, carte blanche, to the provider from the teaching institution. This is contrary to the law and Congressional intent." A.R. at 7. Although at least one other court has adopted the interpretation of the redistribution principle espoused by the Hospital, *see Ohio State Univ.*, 777 F.Supp. at 586-87, this court is compelled to conclude that the Secretary 's interpretation finds support in the unambiguous language of the regulation and is, therefore, entitled to deference.

There can be no argument that the regulation evidences an intent that the Medicare program "should share in the support of educational activities customarily and traditionally carried on by providers in conjunction with their operations." 42 C.F.R. § 413.85(c). Equally clear, however, is the mandate that the Medicare program shall not "participate in increased *costs* resulting from *redistribution of costs* from educational institutions or units to patient care institutions and units." *Id.* (emphasis added).

The court concurs with the Secretary's conclusion that the regulation admits of only one interpretation, to wit, if the costs of activities customarily and traditionally carried on by providers in conjunction with their operations have

been absorbed by an educational unit, such costs may not later be redistributed to a patient care unit. It is clear that what the regulation prohibits is the "redistribution of costs." Any other interpretation would clearly run afoul of the principal that a regulation will be construed to give effect to its plain meaning. Moreover, despite the Hospital's protestations to the contrary, the court finds the Secretary's interpretation of the redistribution principle as applied to the facts of this case to be consistent with earlier applications in other disputes concerning the proper level of reimbursement for educational activities. *See, e.g., Ohio State*, 777 F.Supp. at 586.

It is uncontroverted that the excess costs claimed by the Hospital in fiscal year 1985 previously were borne by the Medical School. A.R. at 209, 328. Therefore, despite careful consideration of the Hospital's assertion that its increased claim represented a refinement of its cost-finding techniques rather than a redistribution of costs, based upon application of the plain language of the regulation to the facts established at the PRRB hearing, the court must agree with the Secretary's conclusion that the increased claim for reimbursement represents an impermissible redistribution of costs from an educational institution, the Medical School, to a patient care institution, the Hospital.

4. *The Related Organization Principle*

Throughout the proceedings conducted in connection with this matter, the Hospital has asserted that costs incurred by the Medical School in support of the GME programs are reimbursable pursuant to the Medicare program's related organization principle. This principle, codified at 42 C.F.R. § 413.17, is as follows:

> Cost to related organizations.
>
> (a) *Principle*. . . . [C]osts applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common

> ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

This regulation is designed to avoid payment of a profit to the provider through a related organization and to avoid payment of artificially inflated costs that may be generated by less than arms-length bargaining. A.R. at 8.

The Secretary takes the position that the related organization principle does not operate to expand the categories of costs allowable under the Medicare reimbursement system, a position with which the Hospital does not take issue. A.R. at 8; *Pl.'s Motion for Summary Judgment* at 43. At issue is the application of the principle to the facts of this case.

Specifically, the Secretary asserts that 42 C.F.R. § 413.17 is a general regulation applied at the threshold to all costs incurred by a related organization in delivering patient care. Consequently, the Secretary reasons, even if the excess costs now in dispute were allowable under the related organization principle, the more specific regulation governing educational activities, 42 C.F.R. § 413.85(c), would then apply, thereby prohibiting reimbursement of costs incurred by a related organization if such costs represent a redistribution from a related educational institution to a patient care institution.

By contrast, the Hospital asserts that the excess costs presently in dispute would have been eligible for reimbursement had they been incurred directly by the Hospital in delivering educational activities to its residents and interns. Therefore, the Hospital concludes, these same costs are reimbursable pursuant to 42 C.F.R. § 413.17 despite the fact that they were incurred by a related educational institution.

Application of the related organization principle in the manner urged by the Hospital would render the redistribution principle almost completely meaningless, a result in conflict with the most basic rules of statutory construction as well as commonsense. On the other hand, the court finds the Secretary's application of the related organization principle in light of the redistribution principle not only reasonable, but also consistent with legislative intent. Consequently, this application will be accorded deference.

CONCLUSION

Regulatory interpretation of a statute by the agency charged with its administration must be given great deference. This fundamental principle of administrative review is particularly appropirate where the agency's interpretation must be applied to resolve disputes arising under a complex reimbursement scheme such as Medicare. Absent a finding that the Secretary's application of the relevant reimbursement principles to the facts of this case is arbitrary, capricious, an abuse of discretion, not in accordance with the law, unsupported by substantial evidence or inconsistent with prior pronouncements, the court may not reject the Secretary's findings, upset conclusions based upon a reasonable interpretation of program regulations, or reverse decisions reflecting a proper exercise of agency discretion.

The court finds the Secretary's determination that the excess costs claimed by the Hospital for fiscal year 1985 represent an impermissible attempt to redistribute costs historically borne by the community, in this case the University's Medical School, is supported by substantial evidence and is reasonable. Consequently, the Secretary could properly conclude that the increased costs claimed for faculty salaries and fringe benefits, the salaries and fringe benefits of the faculty's clerical staff and facilities costs in connection with the operation of the Hospital's

GME program ($2,431,244) as well as the indirect administrative costs incurred by the Medical School for GME program related activities ($430,003) are not reimbursable under the Medicare program.

An appropriate order follows.

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT
OF PENNSYLVANIA

Civil Action 90-2036

THOMAS JEFFERSON UNIVERSITY
d/b/a THOMAS JEFFERSON UNIVERSITY HOSPITAL

v.

LOUIS W. SULLIVAN, M.D., SECRETARY, DEPARTMENT
OF HEALTH AND HUMAN SERVICES

ORDER

[Filed May 1, 1992]

AND NOW, this 1st day of May, 1992, upon consideration of the parties' cross-motions for summary judgment, the responses thereto, the administrative record created in connection with this matter and oral argument presented by the parties, and for the reasons set forth in the accompanying memorandum, IT IS HEREBY ORDERED that

1. Plaintiff shall submit, within 10 days of the date of this order, an affidavit setting forth the date upon which the final decision of the Secretary denying reimbursement of certain costs claimed by the Hospital for fiscal year 1985 was received.

2. Plaintiff's motion for summary judgment is DENIED.

3. Defendant's motion for summary judgment is GRANTED.

4. Judgment is entered for the DEFENDANT and this case shall be marked as CLOSED.

/s/ William H. Yohn, Jr.
WILLIAM H. YOHN, JR.
Judge

[Entered: 5-4-92, Clerk of Court]

APPENDIX D

HEALTH CARE FINANCING ADMINISTRATION
Decision of the Administrator

In the Case of:

THOMAS JEFFERSON UNIVERSITY HOSPITAL,
Provider

vs.

AETNA LIFE INSURANCE COMPANY,
Intermediary

Claim for: Provider Cost Reimbursement Determination of Reasonable Costs for Cost Reporting Period(s) Ending 06/30/85

Review of: PRRB Decision No. 90-D05

Dated: November 17, 1989

This case is before the Administrator, for review of the Provider Reimbursement Review Board's (PRRB) decision. The review is during the 60-day period in Section 1878(f)(1) of the Social Security Act, as amended [42 USC 1395oo]. The parties were notified of the Administrator's intent to review the PRRB's decision. Comments were received from the Bureau of Policy Development (BPD), the Intermediary, and the Provider. Accordingly, this case is now before the Administrator for final agency review.

ISSUE

The issue involves certain graduate medical education (GME) costs claimed by the Provider. The Provider claimed these costs as a result of a cost study it conducted

to determine reimbursement for medical education costs in 1985.

The Board held that the Provider could claim reimbursement for the amounts of GME and physician administrative costs documented by the Provider's cost study. The Board found that the cost study resulted in the refinement of costs and not a redistribution. The Board determined that the cost study did not shift costs from the medical school in violation of the regulation.[1] The Board in coming to this conclusion defined "redistribution" with respect to educational "activities" and not the "costs" associated with the activity. The Board found that the Provider's failure to claim these costs prior to 1984 was an "error" which could be corrected without violation of the redistribution principle.

Additionally, the Board held that Intermediary Letter (I.L.) 78-7, which is a statement of Medicare policy on this issue, implies that the medical school support items can be included in the cost determination without influencing redistribution, and, therefore, supports the Board's decision. Accordingly, the Board found that the Medicare Program is not, by this decision, incurring additional costs previously borne by the community.

Comments

BPD requested that the Board's decision be modified to allow only the direct faculty compensation costs traditionally borne by the Provider. The Board has incorrectly determined that the Provider's cost study did not shift costs from the medical school in violation of the community support and redistribution principle set forth in 42 CFR 413.85. This regulation makes clear that there should not be a redistribution of costs from the educational institution to the provider. The community has undertaken to support these activities, when the costs of

[1] 42 CFR 405.421 (1985), recodified at 42 CFR 413.85.

certain educational activities have been historically borne by the medical school and they may not subsequently shift those costs to the Medicare program.

The BPD acknowledged that there may be an increase in the absolute costs incurred by the Provider over time, but that there should not be an expansion of the types of costs that a Provider incurs for educational activities. Since the Provider historically identified and only claimed the costs for a proportionate share of direct faculty compensation costs, the remaining costs at issue are not allowable.

Similarly, the related organization principle is not intended to expand the range of items and services for which a provider can claim Medicare reimbursement. The related organization principle can not be used to redistribute costs from the educational institution to the provider. Consequently, I.L. 78-7 must be read to be consistent with the specific controlling regulations on medical education costs. Costs recognizable under I.L. 78-7, would be allowable only if these costs were traditionally borne by the Provider. Further, the general and administrative costs of the medical school are never reimbursable pursuant to I.L. 78-7 or the related organization principle.

The Intermediary commented that the University's GME program predates the Medicare program. The Intermediary objected to the Board's decision on two issues; the validity of the Provider's study and the redistribution of medical education costs. The Intermediary challenged the Provider's study based on the fact it was done after the time period at issue and was based on estimates.

Additionally, the Board in an earlier Board decision [2] defined redistribution in terms of the costs not the activity.

[2] *University of Mississippi Teaching Hospital*, PRRB No. 89-D13.

The Intermediary states that the Provider's own witness acknowledged that the costs previously borne by the school were now being borne by the Medicare program as a result of the Provider's cost study.

The Provider commented that the Board's decision properly found that the methodology of the Provider's study was valid and acceptable. Likewise, the Board properly analyzed the prohibition on redistribution as activity related, not cost related. The provider has engaged and been reimbursed for GME activities since 1974. The 1985 claim represents a refinement of cost finding methodology and not a redistribution of costs in relation to activities not previously claimed by the Provider.

DISCUSSION

The record which was furnished by the PRRB has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. All comments are included in the record and have been considered.

There are two issues before the Administrator. (1) Whether the costs disallowed by the Intermediary are a redistribution of costs from the educational institution to the hospital in violation of the regulation at 42 CFR 413.85; and, if not, (2) whether the general and administrative costs of the university medical school, claimed by the Provider, are allowable medical education costs pursuant I.L. 78-7 and the Medicare regulations.

The cost year at issue, in this case, is the first year that the Provider operated under the Prospective Payment System (PPS). PPS provides for the reimbursement of operating costs through the calculation of payment fees. Under Sections 1886(a)(4)[3] and (d)(1)(A)[4] of the Act, the costs of approved medical education activities are spe-

[3] 42 USC 1395ww(a).

[4] 42 USC 1395ww(d). *See* 42 CFR 412.1 and 42 CFR 413.113.

cifically excluded from the calculation of the payment rate under PPS. These cost are reimbursed on a reasonable cost basis and excluded from PPS as a "pass-through." Section 1861(v)(1)(a) of the Social Security Act, as amended, defines reasonable cost as the cost actually incurred. The regulation at 42 CFR 413.9 [5] requires that in determining reasonable costs the services rendered must be related to patient care.

The Provider is an approved operator of graduate medical education programs. The affiliation of the Provider and the University predates the Medicare program. Prior to 1974, the Provider's educational program was solely supported by the community, i.e., tuition, hospital fees, grants, bequests, and state funded support from Pennsylvania and Delaware. From 1974 on, the Provider has claimed a proportionate share of direct faculty compensation costs.

For the 1985 cost year, the Provider had a study conducted to identify the "full cost" of its graduate medical education program. It then sought to claim, as allowable costs, those costs which were identified by the study, but not heretofore claimed as an expense of the Provider. The Intermediary denied the additional types of costs identified by the Provider's 1985 cost study. These included clerical salary and costs, faculty-related space and non-salary direct costs and indirect costs, e.g., non-faculty departmental costs such as general and administrative costs which support general departmental functions of the Medical School.

42 CFR 413.85(a)(1) provides for reimbursement for approved educational activities engaged in by the Provider to enhance the quality of patient care in an institution. In conjunction with this, 42 CFR 413.85(c), in defining educational activities, provides that:

[5] Formerly codified at 42 CFR 405.451.

> "Many providers engage in educational activities . . . These programs contribute to the quality of patient care . . . and are necessary to meet the community's needs for medical and paramedical personnel. It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the program will participate appropriately in the support of these activities. . . ." [6]

Likewise, Section 406 of the Provider Reimbursement Manual (HIM-15) states that:

> "The traditional practice followed in the past with respect to *types of services rendered and the costs related thereto* between providers and educational institutions shall be followed." (emphasis added)

The specific regulation at 42 CFR 413.85(c) and the Congressional mandate it articulates specifically refers to and prohibits the redistribution of the "costs" of the educational activities. Congress, in passing initial Medicare legislation noted:

> "Educational activities enhance the quality of care in an institution, and it is intended until the community undertakes to bear such *cost* in some way, that a part of the net *cost* of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the costs of patient care, to be borne to an appropriate extent by the hospital insurance program." [7] (emphasis added)

[6] *See* Section 404.2 of the Provider Reimbursement Manual.

[7] 89th Cong. 1st Sess., Senate Report 404, pg. 36, *reprinted in* 1965 U.S. Code Cong. & Ad. News, Vol. 1., pg. 1977. *See St. John's*

Consistent with this, the regulations at 42 CFR 413.85(c) states that:

> "Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, *it is not intended that this program should participate in increased costs resulting from the redistribution of costs from educational institutions . . . to patient care institutions . . .*" (emphasis added)

Upon the implementation of PPS and the corresponding provision for pass-through medical education costs [8], it became apparent that teaching hospitals' were attempting to claim costs not previously the responsibility of the Provider or reimbursed by Medicare.[9] These costs were an improper redistribution of teaching institutions costs to hospital medical education costs. This prohibition against the redistribution of costs was not new, as suggested by the Provider, but rather the application of established Medicare policy, to an attempt by the teaching hospitals to improperly increase reimbursement in response to the medical education pass-through provisions of PPS.

The Administrator finds that the Board erred in holding that the "redistribution" principle only related to "activities" and not "costs." Under the Board's analysis, all

---

Hickey Memorial Hospital v. Califano, 599 F.2d 803 (7th Cir. 1979) [1979-1 Transfer Binder] Medicare & Medicaid Guide (CCH) Para. 29733 at 10,321. In that case the court states that:

> "The legislative history of the Medicare Act clearly shows that the Medicare program was intended to pay its share of a hospital's cost of educational activities contributing to patient care until such *costs* are borne by the community served by the hospital." (emphasis added)

[8] P.L. 97-248.

[9] Medicare Regional Intermediary Letter No. 87-9.

costs for pre-existing activities may be shifted, carte blanche, to the provider from the teaching institution. This is contrary to the law and Congressional intent.

In this case, the Provider has attempted to claim costs historically borne by the University Medical School. From 1974 to 1983, the Provider has been reimbursed for a proportionate share of the direct faculty compensation costs.[10] The Provider has attempted to radically expand the types of costs claimed by the Provider for educational activities. Congress intended that, until the community undertakes to bear such education costs in some way, the Medicare program should bear some portion of the costs of educational activities as an element in the costs of patient care. Evidence in the record shows that these cost have been historically borne by the community. The Medicare program was enacted to provide a hospital insurance and basic protection against the costs of hospital care for the aged, and not intended to subsidize medical education programs already supported by the community.

Consequently, the Board improperly determined that the Provider's failure to claim these costs in an earlier cost year was an "error", which it was just attempting to correct. Rather, that the Provider did not claim these costs in an earlier cost year is evidence of the communities support for these activities. To allow the community to withdraw that support and pass these costs to the Medicare program would result in a redistribution of costs in violation of 42 CFR 413.85(c). It would in fact be the precise activity Congress intended to prevent. To allow it would encourage the community to abdicate its commitment to education to an insurance program intended to provide care for the elderly.

---

[10] The record indicates that the Provider claimed clerical and office space costs in 1984, which the Intermediary acknowledges it mistakenly allowed. The Intermediary realized its error during the Board hearing, which was beyond the time allowed for the Intermediary to reopen the cost report pursuant to 42 CFR 405.1885.

Additionally, the general and administrative costs of the university medical school would not be allowable medical education costs under any circumstance. The Provider maintains that 42 CFR 413.85 mandates the use of full costing principles using the best available statistics. As related parties under 42 CFR 413.17 (formerly 42 CFR 405.427), the Provider alleges that the full cost of medical school services related to patient care, including indirect or overhead costs, are allowable costs of the Provider.

However, the Provider, while relying on I.L. 78-7, recognizes that it does not allow for the general and administrative costs of the university medical school claimed by the Provider.[11] Specifically, I.L. 78-7 states that allowable costs incurred in the medical school for items other than faculty direct costs, applicable fringe benefits, etc. as defined above are limited to direct costs and space costs. Contrary to the Provider's contentions, the purpose of the related organization pinciple is to avoid the payment of a profit factor to the provider through a related organization and to avoid payment of artifically inflated costs which may be generated from less than arms-length bargaining. The related organization policy of 42 CFR 413.17 [12] does not expand items or services allowable under Medicare principles as the Provider would have it do. Only those costs that are incurred by the university medical school which can be directly related to the training program for the interns and residents working in the university hospital may be allowed. The general and administrative costs of the university medical school claimed by the Provider fail to meet this criteria for allowable costs.[13]

Consequently, the Provider improperly tried to redistribute costs traditionally borne by the community, i.e., the

[11] Provider's Position Paper, p. 14.

[12] *See* Section 1000 of the Provider Reimbursement Manual.

[13] I.L. 78-7.

university medical school, in violation of the regulation at 42 CFR 413.85(c) and Congressional intent. Additionally, the general and administrative costs of the university medical school, which the Provider claimed in violation of 42 CFR 413.9, 42 CFR 413.85 and I.L. 78-7, are not allowable cost.

DECISION

Accordingly, the Administrator modifies the decision of the Board. The Provider may only be paid for those medical education costs which it has traditionally claimed and been allowed prior to 1984.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 1/18/90

/s/ Louis B. Hays
LOUIS B. HAYS
Acting Administrator
Health Care Financing
Administration

APPENDIX E

PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION

90-D5

Case No. 86-1588

PROVIDER—THOMAS JEFFERSON UNIVERSITY HOSPITAL
PHILADELPHIA, PA

Provider No. 39-0174

VS

INTERMEDIARY—AETNA LIFE INSURANCE COMPANY

Date of Hearing—June 19 and 20, 1989

Cost Reporting Period Ended June 30, 1985

INDEX

ISSUE:

Whether the Intermediary's adjustments disallowing portions of the medical education costs claimed by the Provider were proper?

SUMMARY OF FACTS:

Thomas Jefferson University (University) is a private, not-for-profit entity which operates the Jefferson College of Medicine (Medical School) and a 700-bed teaching hospital (Provider). The Provider is the licensed operator of graduate medical education (GME) programs involving various medical specialties and subspecialties for 320 full time equivalent residents. For the cost reporting period in contention, the Intermediary made a series of adjustments disallowing amounts claimed by the Provider for the GME programs and for Medical School faculty services associated with the administration of hospital departments (Provider Exhibit 2). Based on the Intermediary's adjustments, the amount of Medicare reimbursement in dispute is approximately $815,000. The Provider appealed the Intermediary's determination to the Provider Reimbursement Review Board (Board) pursuant to 42 CFR 405.1835ff and has met the jurisdictional requirements therein.

Background:

As the operator of the GME programs, all of the formal education of the residents takes place within the Provider's facilities. However, the supervision and education of the residents are performed by the Medical School's faculty members. Historically, the Provider has reimbursed the Medical School for the proportionate share of faculty salaries and fringe benefit costs attributable to GME teaching efforts and other hospital administrative duties. These reimbursements were made by a combination of direct salary payments to the faculty or through a transfer of funds to the Medical School for professional

services. The portion of faculty salaries related to GME and administrative services has been traditionally determined through the use of the Provider's Personnel Activity Report (PAR) system. These reports, which are completed by the faculty members on a biannual basis, were used to substantiate the amounts transferred and also formed the basis for the Provider's reimbursement claims. Until fiscal year 1985, the amount of claimed salary and fringe benefit costs associated with the GME programs and with hospital administration had always been allowed by the Intermediary.

Prior to 1984, the Provider reviewed its claims for medical education and faculty administrative costs to determine whether it was properly identifying the actual costs in accordance with Medicare policy. Based on this review, additional clerical costs associated with faculty time spent on GME were identified and claimed in its cost report for fiscal year 1984 and were allowed by the Intermediary. In an effort to refine further its cost-finding technique, the Provider engaged an accounting firm to conduct a cost study which could form the basis for the 1985 reimbursement claim. Under the full costing approach used in the cost study, two categories of costs were identified:

(1) Direct Costs—faculty-related costs which include faculty salary and fringe costs, clerical salary and fringe costs, faculty-related space and non-salary direct costs; and

(2) Indirect Costs—non-faculty departmental costs, such as general and administrative costs which support general departmental functions of the Medical School and which are a necessary function of the GME costs.

The study was completed in late 1985 and documented total GME costs of $6,614,724 and total faculty administrative costs of $2,191,481.

Because the cost study was not complete at the time the fiscal year 1985 cost report was prepared, the Provider made adjustments to its cost report (A-8 adjustments) increasing the amounts claimed for GME and physician administrative costs by $4,000,000 and $452,000, respectively. These A-8 adjustments were made to increase allowable costs by amounts the Provider estimated would be supported by the cost study. Since faculty salaries of $4,737,219 were already included in the GME cost center, the total GME costs claimed on the filed cost report was $8,737,219. The aggregate amount claimed for physician administrative services, including the A-8 adjustment, was $2,032,380. The Provider acknowledges that the estimated amounts claimed on the cost report should be reduced to the actual amounts later supported by the cost study.

When the Intermediary audited the Provider's cost report in December 1985, time constraints precluded a complete review of the cost study. To calculate GME and physician administrative costs for fiscal year 1985, the Intermediary applied an inflation factor to the costs allowed in fiscal year 1984. The application of this methodology by the Intermediary resulted in allowable costs of $4,183,480 for GME and $1,761,478 for physician administrative services. Accordingly, the Intermediary effected a series of adjustments to reduce the Provider's claimed amounts to its allowable cost determination. The following is a reconciliation of the estimated costs claimed by the Provider versus the amounts ultimately supported by the cost study and the amounts allowed by the Intermediary:

	Graduate Medical Education Costs	Physician Administrative Costs	Total
Estimated Amounts Claimed by Provider on Cost Report	$8,737,219	$2,032,380	$10,769,599
Amounts Supported by Cost Study	$6,614,724	$2,191,481	$ 8,806,205
Amounts Allowed by Intermediary	$4,183,480	$1,761,478	$ 5,944,958
Allowable Amounts in Contention	$2,431,244	$ 430,003	$ 2,861,247

Provider's Contentions:

The Provider contends that it is entitled to reimbursement for the full direct and indirect costs incurred by a related Medical School in support of GME programs carried on in the hospital. In support of this contention, the Provider cites various provisions within 42 CFR 405.421 which define allowable education costs as follows:

> (b) . . . Approved educational activities means formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution . . . .
>
> (c) . . . These programs contribute to the quality of patient care within an institution and are necessary to meet the community's needs for medical and paramedical personnel . . . .
>
> (g) . . . For this purpose, a provider's total costs include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities as determined under the Medicare cost-finding principles in § 405.453.

The Provider states that the medical education cost study performed in 1985 was designed as a cost finding tool to identify total allowable GME costs. The Provider asserts that the detailed methodology employed by the study enabled it to identify with a high degree of accuracy the full faculty related and administrative costs incurred for the GME programs and which it is entitled to claim consistent with the full costing approach specified in 42 CFR 405.421 and 405.453 and the related party rules established under 42 CFR 405.427. Under the methodology used, faculty costs were allocated through the use of the 1985 data reported by the PAR system which determined the amount and percent of time each faculty member spent among the following:

> (1) Institutional and clinical supervision of hospital-based residents and interns;
>
> (2) Clinical supervision of medical students and other paramedical specialties; and
>
> (3) The amount of administrative time relative to approved programs (By-product of faculty effort survey).

The percentage of faculty time spent in approved GME programs was used to calculate the Provider's total allowable faculty-related costs. Non-faculty departmental costs related to GME were determined based on a ratio of the number of residents and interns to the total number of students in the Medical School. The direct costs analyzed were then tested against the reasonable compensation equivalent (RCE) limits established under 42 CFR 405.482 to ensure that the claimed costs did not exceed the amounts considered reasonable by the Medicare program. In the few instances where the RCEs were exceeded, the excess was subtracted to comport with Medicare guidelines.

The Provider contends that it has presented substantial uncontroverted evidence that the 1985 cost study is re-

liable, verifiable and was conducted in accordance with Medicare policy and regulations. By contrast, the Intermediary has introduced no probative evidence as to any deficiency in the study. Moreover, subsequent to the initial audit, the Intermediary did review the cost study and found no specific problems or deficiencies in the methodology or calculations. In fact, the Intermediary acknowledged the following in correspondence to the Health Care Financing Administration (HCFA):

> During this field audit review, the auditors traced and verified the Cost Study to source records with only very minor discrepancies. All of the Cost Study methods were consistent with the internal funding method, just far more comprehensive. (Provider Group Exhibit 5, at I-B)

The Provider notes that, despite the lack of any evidentiary support, the Intermediary suggests that the PAR system, upon which the cost study is based, is somehow not reliable. In response, the Provider points out that the PAR system historically has been used as the basis for determining the percentage of faculty time spent in relation to GME activities, and is the same system that the Intermediary has audited in the past and found to be reliable in each of its prior cost reports. The Provider concludes that the Intermediary has never raised any question as to deficiencies in the PAR system in the past and, therefore, the current attack is unwarranted and unsupported.

The Intermediary also contends that the increased educational costs claimed in fiscal year 1985 resulted from a redistribution of cost, and that such redistribution is specifically prohibited under the regulations and various other policy pronouncements. Responding to this argument, the Provider contends that it has engaged in educational activities, and specifically GME programs, since at least 1974, and has claimed and been reimbursed for the costs associated with those programs throughout the 11

year period. The Provider asserts that it is the intent of the Medicare program to share in the costs of educational "activities" traditionally engaged in by providers when the community has not undertaken to bear the cost, and cites the following relevant part of 42 CFR 405.421:

> (c) *Educational activities.* Many providers engage in educational activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties. These programs contribute to the quality of patient care within an institution and are necessary to meet the community's needs for medical and paramedical personnel. It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the program will participate appropriately in the support of these *activities.* Although the intent of the program is to share in the support of educational *activities* customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units. (Emphasis Added)

Whereas the wording of 42 CFR 405.421 is not clear as to what is meant by redistribution, the Provider notes that the regulation does focus on Medicare's intended support of "activities" traditionally carried on in the provider, which would suggest that the redistribution language is "activity" related. If the activity is one historically engaged in, the costs associated with the activity

are reimbursable. Using the Intermediary's interpretation, a cost component analysis would be necessary to determine whether the costs associated with the activity have historically been claimed. The Provider believes the Intermediary's interpretation of the regulation is impractical because such an interpretation would result in the Medicare program sharing not in the reasonable costs incurred by the provider, but rather only in the costs actually claimed by the provider at the inception of the Medicare program. The Provider argues that the categories and amounts of costs it has incurred in relation to the GME programs have increased dramatically since 1966 (e.g. College of Medicine operating costs tripled from 1972 through 1984) and, therefore, it is not practical to be bound to those categories of costs that existed when its first cost report was submitted.

The Provider also refers to the related party rules under 42 CFR 405.427. Under those rules, it is the actual costs incurred by the related organization that are reimbursable, not its charges, even if the charges are less than the costs. Thus, the only questions in related party transactions are whether the costs incurred are related to patient care services, whether they are reasonable, and whether they are the types of costs that would be reimbursable had they been incurred by the hospital directly. The Provider asserts that the regulations at 42 CFR 405.421 and 405.427 are not inconsistent, and there is no redistribution as long as the costs incurred by the Medical School are associated with programs historically carried on by the Provider and are related to patient care.

The Provider also contends that its "activity" related interpretation is further supported by the manner in which HCFA has interpreted the redistribution language. As evidence of HCFA's interpretation, the Provider refers to Intermediary Letter 78-7 (IL 78-7) in which HCFA issued guidelines for teaching hospitals claiming costs incurred by related medical schools. IL 78-7 specifically recognizes as allowable costs the reasonable medical

school costs incurred in support of GME programs. The Provider notes, however, that the IL does not state that such programs must first be evaluated to determine whether a redistribution occurred, nor is there any mention that teaching hospitals can claim as related party medical school costs only those costs which they have historically claimed. The Provider also refers to other recent HCFA correspondence, including HCFA's reply to the Intermediary in the instant case, in which no mention is made that the reporting of costs not previously claimed constituted a redistribution. Moreover, HCFA's concerns focused on (1) whether the clinical training activity was directly related to rendering patient care services, and (2) the need to determine if the community is fully supporting the medical education activities of the college or if additional participation is necessary from the Medicare program. In response to the Intermediary's inquiry in the instant case, HCFA never suggested that the Provider would not be entitled to reimbursement for costs not previously claimed.

In reference to the Board's decision in *University Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Mississippi, Inc.*, PRRB Decision 89-D13, (December 29, 1988), the Provider believes the Board rightfully applied the redistribution language in upholding the disallowance of costs related to the School of Nursing and the School of Health Related Professions. In that case, the Board found that the activities being claimed related to the academic training of nurses and, in addition, were not engaged in by the provider, but rather by nonproviders. The Provider notes that it is neither claiming costs associated with nonprovider activities nor with undergraduate activities. As the licensed operator of GME programs conducted in the hospital, the Provider is claiming only those allowable costs associated with the GME programs that it has historically engaged in and for which it has historically been reimbursed.

This is not the type of situation to which the redistribution language should be applied.

Under the provisions of 42 CFR 405.421, the Medicare program will share in the reasonable costs of approved educational programs until such time as the community has met its obligation to support those programs. The Provider asserts that the community has not met its obligation of support with respect to its GME programs. Whereas the University receives appropriations from the states of Delaware and Pennsylvania, those appropriations have dropped precipitously from 35 percent of the Medical School's operating costs in fiscal year 1972 to 16 percent for fiscal year 1983. More importantly, the Provider points out that the state appropriations are not available to fund GME programs since they are limited in use to undergraduate medical education. Accordingly, the University is forced to defray the costs of residents training through its own resources. In addition to the use of endowment funds, the GME programs are also supported in part by tuition fees, which have risen 360 percent since fiscal year 1973. Since only undergraduate medical students pay tuition, these students are in effect paying for the GME programs which do not directly benefit them at that point of their education.

The Provider further argues that it is not clear whether the community support concept has any relevance to the issue of resident training. Whereas the concept of community support is based on the notion that society as a whole should undertake support of formal classroom training of doctors, nurses and other health care professionals, it is also a matter of public policy that the users of services are the ones who should support the clinical training of the providers of those services. The training of residents involves practical hands-on experience which relates directly to diagnosis and treatment and, thereby, directly benefits patients. Accordingly, it is appropriate that the costs of these efforts be borne by the patient.

The Provider contends that its cost study has accurately identified those costs related to clinical programs which directly enhance patient care and, thus, it is entitled to the full reimbursement of costs associated with its GME programs in accordance with Medicare policy and regulations.

Intermediary's Contentions:

It is the Intermediary's primary contention that the incremental education cost claimed by the Provider in fiscal year 1985 was due to the shifting of costs from the Medical School, which is a direct violation of the community support and redistribution principles set forth in 42 CFR 405.421. The Intermediary cites the following pertinent section of 42 CFR 405.421(c) to support its position:

> It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear the costs, the program will participate appropriately in support of these activities. Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, *it is not intended that this program should participate in increased costs resulting from REDISTRIBUTION of costs from educational institutions or units to patient care institutions or units.* (Emphasis Added)

Whereas the issue under appeal in this case was triggered by the elaborate and expansive cost shifting which occurred in 1985, it is the Intermediary's contention that earlier redistributions of costs from the Medical School to the Provider are also relevant to this appeal. The University has a long history of being self-supporting or community supported and, prior to 1974, Medicare fund-

ing was not required. In 1974, the Provider commenced shifting costs from the community to the Medicare program. Additional cost shifting occurred in 1984 when certain clerical costs of the Medical School were included in the Provider's cost report. However, the Intermediary believes that in 1985 the Provider overstepped the bounds of the regulations and an adjustment to claimed educational costs became necessary.

The Intermediary contends that a review of regulation 42 CFR 405.421 and its legislative history clearly shows that it was the intent of Congress to reimburse only medical educational activities engaged in by providers which had not been undertaken by the community. The Intermediary notes that the reimbursement principles adopted by the Medicare program were derived from the existing reimbursement policies established by the American Hospital Association (AHA). The Intermediary refers to section 2.302 of AHA's Principles of Payment for Hospital Care which states:

> In determining reimbursable cost, a reasonable amount for medical, nursing and other education not reimbursed through tuition, or through scholarships, grants, and other community sources is a legitimate inclusion in the interest of continuing to upgrade quality of service to the community.
>
> COMMENT . . . Ideally, the cost of educating and training the technical and professional health services personnel needed for community service, for industry, or for other health activities should be financed by the whole community through a combination of public resources and private contributions, rather than by the sick patient representing a small percentage of the community who is usually in the poorest position to meet such cost. It will be necessary, however, that the cost of such programs be considered as a factor in determining reimbursable cost of hospital service until the community is prepared to assume this educational responsibility. Hospitals and third-party purchasers must seek methods for transferring this cost to the whole community through concerted joint effort. It must be borne in mind that nursing education traditionally has been supported by hospital income and by the service rendered by student nurses in hospitals. While financing from other methods must be developed, nothing must be done to discourage the education of increasing numbers of nurses prior to the time such cost can be transferred to other sources.

When Congress considered reimbursement mechanisms for the Medicare program, it relied on the AHA principles for guidance. Upon passage of the Medicare Act in 1965, the law was accompanied by a Congressional report which discussed the decision to make medical education an allowable cost. This document states in part:

> Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses, and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution and it is intended, until the community undertakes to bear such educational cost in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program.

The underlying theme throughout the language related to medical education specifically indicates that if the community supports the educational activities, then the Medicare program shall not participate.

In addition to the community support provision, the regulation also adopts the redistribution concept. In response to the Board's request for clarification on the redistribution issue, the Intermediary refers to various HCFA letters

which were prepared in response to specific medical education inquiries made on behalf of different providers (Intermediary Exhibits I-24 through I-27 and I-52). Based on its review of these letters, the Intermediary points to the following pertinent policy applications for determining the proper reimbursement of medical education costs:

(1) IL 78-7 is no longer applicable due to the implementation of the Prospective Payment System (PPS).

(2) The Medicare program has historically included certain medical education cost as allowable costs in recognition of the fact that the general community support of these activities was not fully involved.

(3) Costs incurred directly by a medical school in the operation of its education program cannot be passed through as direct cost to the hospital for PPS purposes, even though the entities are related.

(4) Activities conducted by the faculty of a related medical school that are both related to the care and treatment of the hospital's patients and furnished in support of the clinical training of interns and residents meet the requirements for Medicare reimbursement.

(5) Medical education items and services must be necessary and directly related to the rendition of medical school faculty services in the hospital and may not be duplicative of items and services furnished by the hospital.

(6) The policy concerning related organizations was not intended to expand the range of items and services for which a provider could claim Medicare reimbursements, or to include items and services not specifically related to patient care.

(7) Where costs for items or services related to medical education activities have historically been borne by a university medical school . . . it is our view that the community has undertaken to support these activities. Consequently, their subsequent allocation to a hospital represents a redistribution of costs from an educational institution/unit to a patient care institution/unit. In such situations, these costs are not reimbursable under the Medicare program. Likewise, if the costs of teaching physicians supervising interns and residents have been borne by a medical school and the salaries and fringe benefits of interns and residents have been paid by the provider, the hospital cannot begin claiming Medicare reimbursement for any costs to the hospital of the teaching physicians because such a change represents a redistribution of costs from an educational institution to a patient care institution.

(8) Physicians' approved educational activity services to the provider—This category includes the time a physician spends in teaching activities such as grand rounds, time spent in supervising residents in the care of individual patients with whom an attending physician relationship is not established, and time spent in activities related to other approved provider-operated educational programs.

(9) Nonallowable costs—This category would include such activities as research, supervision of residents not in an approved program, and any medical school activities not directly related to the rendition of patient care services in the hospital.

(10) Where a teaching hospital has never claimed costs incurred by a university medical school, any attempt to include such costs would be considered a redistribution of costs from the medical school to the hospital and would form a basis for the disallowance of such costs.

The Intermediary believes the above cited excerpts from various HCFA communiques fully define the meaning of redistribution or cost shifting and the explicit prohibition of such action in determining allowable medical education costs.

The Intermediary further argues that the Provider has placed undue reliance on the related organization principles under 42 CFR 405.427 and the application of IL 78-7. Whereas the related organization concept would not require an actual payment or recording of costs on the books of a provider, the Intermediary contends that the prevailing regulation in this case is 42 CFR 405.421 which covers medical education activities. Under the provisions of 42 CFR 405.421, it is the Provider that is required to be engaged in the educational activity, and the redistribution language prohibits the reclassification of expense from the Medical School to the Provider (patient care unit). The Intermediary asserts that the medical education regulation is more specific and must, therefore, be given greater weight than other regulations. With respect to the application of IL 78-7, the Intermediary refers to HCFA pronouncement that the IL 78-7 is no longer appropriate with the advent of PPS.

As a secondary argument, the Intermediary questions the validity and applicability of the Provider's cost study, which is the foundation for the costs transferred from the Medical School. In support of its contention that the study is inappropriate, incomplete and inaccurate, the Intermediary cites the following deficiencies:

(1) Failure to comply with the American Institute of Certified Public Accountants' standard for the preparation of workpapers and documentation of source data.

(2) Lack of documents which support the intention, design, development, application, utilization or implementation of the study.

(3) The principal source document used in the study (Personnel Activity Report) to compile and allocate faculty time and associated costs is fatally flawed because it is based on the historical recreation of best estimates, and excludes time spent in private patient care.

(4) The Provider's use of faculty time as the basis for allocating all other costs of the Medical School is an unsubstantiated assumption.

(5) The study relies on the obsolete application of IL 78-7 rather than the basic Medicare principles required by 42 CFR 405.453.

In summary, it is the Intermediary's conclusion that the study is flawed in its design, compilation and assumptions, and is an invalid document to be used for the purpose of shifting costs from the Medical School to the Provider, which in and of itself is not proper under Medicare policy.

CITATION OF APPLICABLE LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. **Law—Title XVIII Social Security Act:**
   - a. **Section 1861(u)** — **Provider of Services**
   - b. **Section 1861(v)(1)(A)** — **Reasonable Cost**
2. **Regulations—42 CFR 405, Subpart D:**
   - a. **Section 405.406 (Redesignated 413.20)** — **Financial Data and Reports**

b. Section 405.421 (Redesignated 413.85) — Cost of Educational Activities

c. Section 405.427 (Redesignated 413.17) — Cost to Related Organizations

d. Section 405.451 (Redesignated 413.9) — Cost Related to Patient Care

e. Section 405.453 (Redesignated 413.24) — Adequate Cost Data and Cost Finding

3. Program Instructions:

a. Provider Reimbursement Manual, Part (HIM 15-1):

Section 406 — Cost of Educational Activities —Program Participation

b. Part A Intermediary Letters (IL):

IL 78-7 — Allowance of Medical School Faculty Costs

FINDINGS AND CONCLUSIONS:

The Board, after consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing and post-hearing briefs finds and concludes that the Intermediary's adjustments were improper and should be modified to allow for the amounts of GME and physician administrative costs documented by the Provider's cost study.

The Board finds that the GME costs identified by the Provider's cost study pertain to services related to the care and treatment of its patients and were furnished in support of the clinical training function of the residents at the hospital. The provisions of 42 CFR 405.421 are the governing regulations for the reimbursement of approved educational activities under the Medicare Program. Paragraph (b) of 42 CFR 405.421 defines approved educational activities to mean formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution. These activities would include graduate medical education programs associated with approved

residency programs. Under the regulations, direct medical education costs are excluded from the definition of operating costs and, accordingly, are not included in the calculation of payment rates under the prospective payment system for inpatient hospital services. Therefore, medical education costs are separately identified and "passed-through" on a reasonable cost basis.

The Board finds that the medical education costs incurred for the Provider's GME programs were reasonable costs which are reimbursable under 42 CFR 405.451 and also meet the specific reimbursement requirements established under 42 CFR 405.421. In accordance with the provisions of 42 CFR 405.451, a provider of services is entitled to reimbursement of its reasonable costs incurred in the provision of patient care services. Reasonable cost includes necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. In addition, reasonable cost must be determined in accordance with other regulations establishing the methods to be used and items to be included. The provisions of 42 CFR 405.421(g) specify that the allowable cost of approved educational activities is net cost determined by deducting tuition revenues from a provider's total cost of the activities. The regulation describes a provider's total costs to include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities as determined under the Medicare cost-finding principles of 42 CFR 405.453. The cost-finding principles of 42 CFR 405.453 require the maintenance of adequate cost information which is accurate and in sufficient detail to accomplish the purposes for which it is intended, and that the data be capable of verification by qualified auditors. Through the cost-finding process, the costs of the various types of services rendered are determined by the identification of direct costs and the proration of indirect costs.

The cost study performed by the Provider complied with the full costing requirements of the regulations by identifying the total allowable costs associated with the GME programs, including direct and indirect costs. Based on the record (Provider Exhibit 3 and Appendices I and Ia) and the testimony of the Provider's expert witness (see especially Board's examination, Transcript—June 19, 1989, pages 188-218), the Board finds the Provider's cost study to be valid and acceptable. The PAR system, upon which the cost study is based, historically has been used as the basis for determining the percentage of faculty time spent in relation to GME activities and is the same system that the Intermediary audited and found to be reliable in prior cost reporting periods. Furthermore, during a field audit review, the Intermediary's auditors traced and verified the cost study to source records with only very minor discrepancies. (Provider Group Exhibit 5, at I-B). Additionally, the auditors found the cost study methods were consistent with the internal funding method, just far more comprehensive. Id.

The Board does not accept the Intermediary's argument that the Provider is shifting costs from the Medical School in violation of the community support and redistribution principle set forth in 42 CFR 405.421(c). The record shows that, historically, the Provider has always utilized the services of the faculty members of its related Medical School for the supervision and education of the residents in its GME programs. Throughout its participation in the Medicare program, the Provider has claimed the costs identified with these educational activities, and there is no evidence that the Intermediary ever disallowed the amounts claimed prior to the year in contention for this appeal. In 1985, the Provider performed an in-depth study of its GME programs in order to identify all costs related to these ongoing activities. The fact that the Provider did not fully identify all of the costs associated with its GME programs in prior years does not prohibit

the correction of this error in the cost reporting period in contention.

The Provider's refinement of its methodology for determining GME costs is permissible under the provisions of 42 CFR 405.421. The regulations at 42 CFR 405.421(c) state the following:

> . . . Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

The term "redistribution" has not been defined in the regulations or other program instructions. However, the use of the term in the regulation is prefaced by the program's intent to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations. In the absence of further clarification, the Board concurs with the Provider's interpretation that the focus of the regulation with respect to redistribution is on educational "activities," and not the "cost" associated with the activity. Accordingly, the concept of redistribution would not apply unless the educational program was a new activity being performed by the provider. In this case, the Provider is merely claiming additional support costs for the GME programs it has historically operated utilizing the services of the related Medical School's faculty. The refinement of costs associated with these educational activities does not constitute a redistribution of costs from the educational unit to the patient care unit.

Moreover, the types of costs identified and the methodology employed under the Provider's cost study are expressly covered in IL 78-7, the program instructions specifically issued for determining the allowable faculty costs of a related medical school. Thus, IL 78-7 implies that

medical school support items can be included in the cost determination without effecting a redistribution. Accordingly, the Board believes that the instructions in IL 78-7 support its conclusion that reimbursement of the costs in question does not constitute a redistribution under 42 CFR 405.421(c).

The Board also finds that the Medicare program is not incurring additional costs previously borne by the community. The record shows that the only community support received by the University was appropriations from the states of Delaware and Pennsylvania. However, since the appropriated funds were specifically earmarked for the University's undergraduate Doctor of Medicine program, community support for the Provider's GME programs was not available from state appropriations (Provider's Post-Hearing Submission/Appropriation for Fiscal Year 1985). The Board also notes that the percentage of Medical School's operating costs covered by the appropriations has declined from 35 percent in fiscal year 1972 to 16 percent in 1983 (Transcript—June 19, 1989, Page 22).

DECISION:

The Intermediary's adjustments disallowing portions of the medical education costs claimed by the Provider were not proper. The Intermediary's adjustments are modified to allow the amounts of GME and physician administrative costs documented by the Provider's cost study.

Board Members Participating:

Elise D. Smith
Arthur P. Owens
Keith E. Braganza
Sally A. Kirkpatrick

FOR THE BOARD:

/s/ Elise D. Smith
ELISE D. SMITH
Chairman

[Nov. 17, 1989]

APPENDIX F

STATUTORY AND REGULATORY PROVISIONS INVOLVED

42 U.S.C. Section 1395x(v)(1)(A)

(v) Reasonable costs

(1)(A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipient of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established

under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

42 C.F.R. § 413.85 Cost of educational activities.

(a) *Payment*—(1) *General rule.* Except as provided in paragraph (a)(2) of this section, a provider's allowable cost may include its net cost of approved educational activities, as calculated under paragraph (g) of this section. The net cost is subject to apportionment based on Medicare utilization as described in § 413.50.

* * * *

(c) *Educational activities.* Many providers engage in educational activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties. These programs contribute to the quality of patient care within an institution and are necessary to meet the community's needs for medical and paramedical personnel. It is recogized that the costs of such educational activities should be borne by

the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the program will participate appropriately in the support of these activities. Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

* * * *

(g) *Calculating net cost.* Net costs of approved educational activities are determined by deducting, from a provider's total costs of these activities, revenues it receives from tuition. For this purpose, a provider's total costs include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities as determined under the Medicare cost-finding principles in § 413.24.

42 C.F.R. § 413.17 Cost to related organizations.

(a) *Principle.* Except as provided in paragraph (d) of this section, costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

* * * *

APPENDIX G

Part A Intermediary Letter, No. 78-7; *Part B Intermediary Letter*, No. 78-7; Feb. 1978

We have reviewed a number of situations of medical school related teaching hospitals to evaluate the costs identified with the services rendered by faculty of the medical school (or organization related thereto) in the hospital. These situations raise questions about the reasonableness of these costs as allowable hospital costs and the appropriateness of the bases used in allocating them to the hospital.

In these situations, reasonable costs incurred by a teaching hospital for patient care services rendered by the faculty of the medical school (including organizations related to the medical school) in the hospital are allowable hospital costs provided such costs would be allowable if incurred directly by the hospital rather than under such arrangement. Reimbursement can be made to the hospital only where the costs of services rendered by the medical school faculty are charged to all components receiving services, including the hospital, on the same basis. The costs of services where the medical school and the hospital are related by common ownership or control are allowable to the hospital, providing the costs do not exceed the price of comparable services that could be purchased elsewhere and providing they are in accord with all other provisions of Chapter 10 of the *Provider Reimbursement Manual (PRM)* [¶ 5677, *et seq.*]. Reimbursement to the hospital for these costs is determined in the same manner as the costs incurred for services rendered by physicians and others on the hospital staff. Allowable costs of the medical school faculty are defined as direct salaries, applicable fringe benefits, employer's portion of FICA taxes, federal and state unemployment taxes and workmen's compensation. Allowable costs may also include the costs of other items (limited to necessary travel,

membership fees, sabbatical leave, and allowance for books) directly applicable to the services rendered by the faculty of the medical school (see attachment—Instructions for Completion of Certain Columns of "Worksheet," Column 7).

The Medicare program will recognize additional costs only if *necessary* and *directly related* to the rendition of medical school faculty services in the hospital. Generally, the only additional costs incurred in the medical school that may be allowable to the hospital relate to a medical library, physician office space and clerical support. In any situation where a hospital has its own medical library (even though less extensive than the medical school library), its own administrative structure, in any form, or provides office space or clerical support to the medical school faculty, the hospital would not be allowed to claim any such additional costs incurred in the medical school for these items. Allowable costs incurred in the medical school for items other than faculty direct salaries, applicable fringe benefits, etc., as defined above are limited to direct costs and space costs. Direct costs are limited to salaries and applicable fringe benefits of personnel directly assigned on the basis of time to the items of claimed costs (e.g., library), payroll related taxes, interest on funds borrowed to purchase movable equipment, depreciation (straight line), insurance and rent on movable equipment, and supplies. Space costs are limited to interest on funds borrowed to purchase buildings and fixtures, depreciation (straight line), insurance and rent on buildings and fixtures, taxes, operation of plant, maintenance of plant, and housekeeping. On the other hand, your attention is drawn here to any costs incurred by the hospital for the medical school which must be excluded from allowable hospital costs (e.g., the costs of meals served to medical school students).

All costs claimed by a hospital for services rendered by faculty of a related medical school and for costs incurred

in the medical school which are related to those services must be substantiated by the provider's completion of the attached "worksheet" and submitted by the provider along with its Medicare cost report. This form must be used effective with all cost reports submitted by the provider to the intermediary for cost reporting periods ending on or after December 31, 1977. Upon submission of the notice of program reimbursement by the intermediary to the provider on its cost report, the intermediary shall forward one copy of the completed "worksheet" to the address below:

Health Care Financing Administration
Medicare Bureau
Division of Provider Reimbursement
and Accounting Policy
6401 Security Boulevard
Baltimore, Maryland 21235

In addition, intermediaries should carefully scrutinize costs claimed for other than medical school faculty services which are incurred in a related medical school and allocated to the hospital. Such review must include an evaluation of the cost in terms of its allowability as being related to patient care furnished in the hospital, the reasonableness of the bases used in allocating the cost to the hospital and the reasonableness of the amount claimed. Reimbursement can be made to the hospital only where the costs of these services are charged to all components, including the hospital, on the same basis. Intermediaries should review these costs claimed on each cost report notwithstanding prior review and should seek appropriate documentation from the provider as may be necessary. This documentation should not be included on the attached "worksheet." Such costs are allowable to the hospital providing they do not exceed the price of comparable services that could be purchased elsewhere and providing they are in accord with all other provisions of Chapter 10 of the ***PRM***.

APPENDIX H

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 92-3045

OHIO STATE UNIVERSITY, d/b/a OHIO STATE HOSPITALS,
Plaintiff-Appellee,

v.

SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Defendant-Appellant.

On Appeal from the United States District Court
for the Southern District of Ohio

Decided and Filed June 8, 1993

Before: MARTIN and BOGGS, Circuit Judges; and CONTIE, Senior Circuit Judge.

MARTIN, Circuit Judge, delivered the opinion of the court, in which CONTIE, Senior Circuit Judge, joined. BOGGS, Circuit Judge, concurs in the result only.

BOYCE F. MARTIN, JR., Circuit Judge. The Ohio State University operates a 905-bed acute-care teaching hospital in Columbus, Ohio in conjunction with its medical school. The hospital, administered by the Ohio State's medical school, trains recently graduated doctors,

called interns and residents, by having them provide patient care. When Medicare was instituted, the federal government began reimbursing the hospital for medical care provided to patients by these doctors. In 1985, the hospital claimed reimbursement from Medicare in the amount of $765,000 for indirect costs only, which were the overhead costs of its graduate medical program for the provision of patient services. Included in that total was the cost of space, salaries, utilities, supplies, etc. which were related to patient services.

A Medicare intermediary, an entity hired by the Department of Health and Human Services to review cost-reimbursement applications, rejected the hospital's request for reimbursement of indirect costs. Another entity, the Provider Reimbursement Review Board, reversed this decision. Another review followed, and the Deputy Administrator of the Health Care Financing Administration of the Department of Health and Human Services reversed the Review Board's decision, agreeing with the intemediary. Review of the Deputy Administrator's denial of reimbursement was made to the federal district court. The district court granted summary judgment for the hospital, concluding that it was entitled to reimbursement of its costs related to patient care under Medicare. We agree with the district court and affirm.

A resolution of the question before us turns on the interpretation of 42 C.F.R. § 413.85. We are thus again sent into the sea of murky precedents to divine our power to overturn an agency's interpretation of its own regulations.[1] As we read *Whiteside v. Secretary of Health*

[1] Quite frankly, the degree to which courts are bound by agency interpretations of law has been like quicksand. The standard has been constantly shifting, steadily sinking, and, from the perspective of the intermediate appellate courts, frustrating. At first, agency interpretations of law were to be reviewed *de novo*. *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944) (". . . interpretations and opinions of the Administrator . . . while not controlling upon the

& Human Svcs., 834 F.2d 1289, 1292 (6th Cir. 1987), we are bound by an agency's interpretation of its own regulations unless its interpretation is not "reasonable, consistent, and persuasive." In this case, the Secretary's interpretation of 42 C.F.R. § 413.85 is neither reasonable nor persuasive.

As we read the statute, 42 U.S.C. § 1395hh, the Medicare program is designed to reimburse certain reasonable and necessary medical expenses. Educational activities,

courts by reason of their authority, do constitute a body of experience and informed judgment. . . .") However, we have been told to give "some deference" to the interpretation of the agency. *FTC v. Indiana Fed. of Dentists*, 476 U.S. 447, 454 (1986) ("The legal issues presented . . . are . . . for the courts to resolve, although even in considering such issues the courts are to give some deference to the [agency's interpretation].") And we have been told that we are not to follow an agency's interpretation if the agency's interpretation violates the specific language of the law. *Demarest v. Manspeaker*, 112 L. Ed.2d 616 (1991) ("But administrative interpretation of a statute contrary to language as plain as we find here is not entitled to deference."). Finally, we have been told that we are not to overturn an agency's interpretation of law if the agency's interpretation is "reasonable." *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc., et al.*, 467 U.S. 837, 845 (1984) (Intermediate court is to determine whether agency's view "is a reasonable one."); *Whiteside v. Secretary of Health & Human Svcs.*, 834 F.2d 1289, 1292 (6th Cir. 1987) (The question for the court is "whether the Secretary's interpretation is reasonable, consistent, and persuasive.")

As we noted in *Whiteside*, 834 F.2d at 1292, an agency's interpretation of the law binds this court when the interpretation is "reasonable, consistent, and persuasive." Of course, no court has stated how to determine which interpretations of a statute are "reasonable, consistent, and persuasive" and which are not. So, after all these years of debate and after much judicial ink has been spilled, we are back to essentially the old rule that courts are not bound by agency interpretations and that courts are to apply laws based on the court's interpretation of the law's reasonable meaning. This entire process, travelling far without going anywhere, could have been avoided if the executive branch were left to enforce the law and the judicial branch were left to interpret the law.

according to 42 C.F.R. § 413.85, are reimbursable, as reasonable and necessary medical expenses if they are: 1) approved programs; 2) contribute to the quality of patient care within a hospital which receives Medicare; and 3) do not redistribute costs from educational institutions to patient care institutions. This issue was resolved precisely in *University of Cincinnati v. Bowen*, 875 F.2d 1207, 1210 (6th Cir. 1989). In the present case, as in the *University of Cincinnati* case, the graduate medical program was accredited and contributed to patient care in the university-run hospital. The Deputy Administrator in this case, however, determined that the Hospital's request for reimbursement for certain overhead expenses constituted an unlawful redistribution of costs from the graduate program to the hospital.

In our opinion, the Deputy Administrator's decision was based on an unreasonable and unpersuasive interpretation of 42 C.F.R. § 413.85(c). That regulation provides,

> Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

The request for reimbursement for indirect costs, known as overhead expenses outside of government, of its graduate medical program does not constitute a redistribution of costs from the medical program to the hospital. The Department interprets the "redistribution" clause of 42 C.F.R. § 413.85 to mean that costs for patient care, at one time paid by educational institutions but subsequently paid by hospitals, are not reimbursable. The Department's interpretation is neither reasonable nor persuasive because it does not comport with the language of 42 C.F.R. § 413.85(c). The language "educational activi-

ties customarily or traditionally carried on by providers in conjunction with their operations" indicates redistribution of kinds of costs, not a temporal redistribution of educational costs. The redistribution clause, therefore, applies to a redistribution of costs from an educational program, such as classroom expenses, to a provider of Medicare medical services. The graduate medical program here does not involve classroom-type expenses, but involves expenses of doctors who are furthering their training by providing medical services. As the district court noted, in finding for Ohio State University,

> [T]he plain meaning of [42 C.F.R. § 413.85(c)] is to authorize reimbursement of all direct and indirect costs related to the kinds of educational activities customarily or traditionally carried on by providers, but to deny reimbursement for costs related to educational activities which are customarily or traditionally carried on by educational institutions, such as medical and nursing schools. The court concludes that the underlying purpose of the redistribution principle is to limit reimbursement to educational costs related to patient care and to deny reimbursement for educational costs unrelated to patient care.

Contrary to the Secretary's interpretation, the district court's interpretation of 42 C.F.R. § 413.85(c) is certainly reasonable and persuasive.

The costs claimed by the hospital are not a redistribution of educational costs unrelated to patient care. They are a cost of providing patient care and are reimbursable under 42 U.S.C. § 1395hh and 42 C.F.R. § 413.85(g), which allow recovery of costs of providers of medical services relating to patient care.

The judgment of the district court is affirmed.

Judge Boggs concurs in the result only.